

Community Service Plan Children's Services

Niagara Region

Prepared by:

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in collaboration with the Niagara Community**

Prepared for:

**The Ministry of Community and Social Services
The Ministry of Children and Youth Services**

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Executive Summary

PREAMBLE

This Community Service Plan is the result of a community-wide collaboration that has created a shared vision for children's mental health services in Niagara. The focus of this plan is on services funded by the Ministry of Community and Social Services (MCSS) and the Ministry of Children and Youth Services (MCYS) that provide support to children, youth and their families experiencing behavioural, emotional, psychiatric and social concerns. It does not include mandatory services offered through the child welfare and young offender systems.

A wide-ranging planning process collected information on the community, the service system, and the experiences of people using the system, as well as those providing the services. It resulted in a vision and a series of strategic directions, goals and priorities that will help set the course for the future development of these services.

INTRODUCTION AND BACKGROUND

The Community Service Plan was created at the request of the Hamilton Niagara Regional Office of MCSS/MCYS. The Regional Office and community organizations are committed to a systems approach to finding the best match between resources and needs. With this in mind, a process was initiated for the development of community service plans for the children's and developmental services sectors in each of the four

communities that comprise the Hamilton Niagara Region. The responsibility for leading this process was placed in the hands of the four Contact agencies – Contact Hamilton, Contact Brant, Contact Niagara and Contact Haldimand-Norfolk – that serve as the single point of access to developmental and children's mental health services in each community.

The plan is designed to provide advice on future resource allocation decisions with regard to children's mental health services. It will also assist community agencies and boards of directors in collective goal setting and future community planning processes. The Ministry-funded children's mental health services in Niagara are delivered by five community agencies: Niagara Centre for Youth Care, Centre de santé communautaire, Niagara Child Development Centre, Hotel Dieu Hospital Health Sciences Centre, and Contact Niagara. In April 2004, the Niagara Centre for Youth Care and the Niagara Child Development were amalgamated to form a new single agency known as Niagara Child and Youth Services. However, they are treated as two separate entities in this report as a result of the data being acquired before the amalgamation.

The process for creating this community service plan was devised as a result of a comprehensive consultation involving input and participation from providers and users of services, as well as other key stakeholders. It was agreed that the process should involve the following five steps:

- Collecting information on patterns to provide an overview of the general population; the current service system; usage rates; and the broader context.
- Collecting information on experience to capture the perceptions and opinions of people requesting service; people receiving service; community groups and organizations; providers of Ministry-funded children's and developmental services; and providers of related services.
- Collating and analyzing information in order to shed light upon perceived strengths or opportunities within the service system; perceived gaps or duplications; issues and/or barriers related to the availability or delivery of services; views regarding priorities for service; and potential trends in a variety of areas relevant to planning. A Technical Advisory Group comprised of a small number of external experts in information collection and analysis would be established to assist in accomplishing this step.
- Developing a shared vision and set of priorities for the children's and developmental services system for the next three years. This would be accomplished through a community consultation process guided by a reference group comprised of key stakeholders.
- Completing a community service plan containing the findings of all previous steps, as well as the agreed-upon vision, priorities and goals.

The process of gathering information and conducting community consultations began in the summer of 2003. A Technical Advisory Group was formed and consultants were hired to assist in gathering the quantitative and qualitative information to address the following questions:

1. What is the nature and magnitude of the demand for Ministry-funded service and supports within a jurisdiction?
2. What resources are available to respond to that demand and how are they currently being used?
3. What are the identified strengths, weaknesses and pressures of the current service system?
4. What should be the priorities for enhancing the current service system over the next three years?
5. Where are the opportunities to address population well-being and achieve positive change within the current system?
6. What are the characteristics of the local community that need to be taken into account when planning?
7. What areas require further exploration?

The answers to these questions are provided in the following sections: a profile of the Niagara community; a description of the service system; a summary of the perspectives of consumers, service providers and allied agencies about the service system; and a statement of the vision, strategic directions, goals and priorities that were established through the Reference Group and community consultation process.

NIAGARA COMMUNITY PROFILE

The first step in creating this Community Service Plan involved collecting information on the community and the general population, in order to describe the social, political and economic context in which planning will take place.

With a population of 410,575, the Niagara Region occupies a 1,896 square kilometre peninsula bounded by the City of Hamilton to the west, Lake Ontario to the north, Lake Erie to the south and the Niagara River that marks the U.S. border to the east. Its two-tier local government structure is headed by a regional council comprised of representatives from twelve local municipalities: Grimsby, Lincoln, St. Catharines, Niagara-on-the-Lake, West Lincoln, Pelham, Thorold, Niagara Falls, Welland, Wainfleet, Port Colborne, and Fort Erie.

Niagara's most heavily populated cities of St. Catharines, Niagara Falls and Welland contain 62 percent of the region's population. Much of the remainder of the region is rural, though there are several other urban areas, widely dispersed around the peninsula,

including Fort Erie, Port Colborne, Grimsby, Thorold and Niagara-on-the-Lake. The widely-dispersed population and large geographic area make it difficult to provide services that are equally accessible to all.

The region attracts millions of visitors every year to Niagara Falls and other popular tourist attractions. The tourism, retail and service sectors therefore loom large in the region's diverse economy which also features transportation, manufacturing telecommunications and agriculture.

The population is growing more slowly than the rest of the province and has a higher concentration of older people, with proportionately fewer children and young people. The birth rate is higher than average, however, it has been projected that the population of children and youth will rise slowly but steadily in coming years.

The community is less ethnically, culturally and linguistically diverse than others in Ontario, though it receives a large influx of refugees at the border post in Fort Erie. Two urban centres – Welland and Port Colborne – have been designated under the French Language Services Act.

Education levels in Niagara are generally lower than elsewhere in the province– a factor that could influence public awareness of services and people's ability to take advantage of them.

Unemployment in Niagara is relatively low, though it fluctuates due to the seasonal nature of the tourist industry. Family incomes tend to be lower than elsewhere in the province. There are more low income people and more people receiving social assistance. These are factors to be considered in planning, not only because low income may contribute to the needs for which families seek help, but also because of its impact on people's ability to access the service system.

All of these characteristics of the community -- its geography, economy, demographics and culture as well as the social circumstances of families and individuals -- must be considered in planning for children's services.

THE CHILDREN'S MENTAL HEALTH SERVICE SYSTEM

This planning process collected and analysed data available from existing sources and agency surveys, in order to provide a description of the Ministry-funded programs and how the programs are classified and funded. It identified the services provided; who receives them; what their needs are; and what types of services that are required. It also indicated the extent to which people have to wait to receive service and how urgent situations are addressed.

The ministry allocates funding to provide specialized services for children and youth experiencing social, behavioural, emotional and psychological problems. The program categories range from residential services to services provided in the home and crisis services. Contact Niagara serves as the single point of access for children and families requiring these services.

The planning process examined the service system by analyzing data from Contact Niagara's WEBTRACKER information system, information from the Ministry of Community and Social Services Detail and Transfer Payment Reports and an Agency Data Template that was completed by each agency for the fiscal year 2002/03.

The agency data templates revealed that 4,117 individuals entered services in 2002/03 and 3,849 received services. The largest age group beginning services was youths aged from 16 to 17 (39.3%), followed by youths 13 to 15 years old (35%).

The WEBTRACKER data, for the fiscal year beginning April 1, 2003 and ending March 31, 2004 showed that Contact Niagara initiated 1,809 referrals on behalf of 1,489 unique individuals. More than 64 percent of the referrals were for counselling services and more than 34 percent of them were for family intervention programs.

WEBTRACKER data also indicated that the waiting list as of March 31, 2004, contained a total of 260 referrals waitlisted, representing 250 unique individuals, 45.8 percent of them waiting for child and family counselling.

Contact Niagara uses a standardized tool called the Brief Child and Family Phone Interview (BCFPI) at the point of intake. Information is gathered on strengths and concerns regarding a child's behavioural and emotional adjustment and the child and family's functioning. The BCFPI measures a number of problem areas where a child may be in need of help. A score above 70 in these problem areas indicates that the child has a high enough risk that he/she is likely in need of mental health services. A study of BCFPI data revealed the following:

- 75 percent of those interviewed had problems in two to six problem areas, while only 7 percent did not have any scores above 70.
- Family adjustment issues were present in 71 percent of the interviews while problems with cooperativeness were present in 69 percent of the interviews.
- About 30 percent of the families come from households with an annual income of less than \$20,000 and 21 percent come from low income single parent families.

Niagara's children's services system received approximately \$5.7 million in annual funding in 2003/04 from MCSS/MCYS. Within Niagara, five transfer payment agencies received funding for children's services. This funding for children's services is provided in 11 different categories of programs, each of which is identified with a unique project code. The project codes are used by the province to classify the categories of services. The money designated for any one code cannot readily be transferred to another. The majority of the funding was allocated between three project codes:

- Child and Family Intervention Operating (Non-residential) - 48.5 percent
- Child and Family Intervention Operating (Residential) -16.9 percent
- Children's Mental Health 0-6 Initiative -10.5 percent

To help explain how this system is structured, a service framework was developed to describe how services are differentiated from one another and organized within the community. It describes services in the following four categories.

- *Highly Specialized Services* include psychiatric support, acute care hospitalization and crisis treatment. These services address the most severe and complex needs of children and youth. They may be located in the community or regionally. Currently, none of these services are being funded through MCSS/MCYS. These services, when required, are primarily funded through the Ministry of Health and Long-term Care.
- *Residential Services* are provided to children in group care or residential settings where the child is receiving care and treatment outside of his/her own home. The intent is to provide these services as close to the child's home as possible. This accounts for 16.9 percent of all resources allocated for children's mental health services in Niagara.
- *Core Services* refers to services such as assessment and clinical services, crisis treatment and home-or-school based services. These represent a broad range of service options, provided in the community. This accounts for 74.8 percent of the resources allocated.
- *Access Services* provide children and their families with information about the system, referral to services and case resolution which involves processes for addressing the complex needs of children in very difficult and challenging circumstances. This accounts for 7.3 percent of the resources allocated.

Two agencies received 88.8 percent of the children's resources. The largest percentage of funding was allocated to the Niagara Centre for Youth Care (45.3%) and Niagara Child Development Centre (43.5%).

Ministry data indicates that the system served 5,917 individuals in 2002/03. However, this statistic does not in fact record the total number of individuals served, but the number

of instances where services are provided. This figure also includes the access statistics. Thus anyone going through the access and referral process (Contact Niagara) would be counted both at the access point and also again when they receive service at the agency. If the access statistics are excluded, the system served 3,731 individuals in 2002/03.

An analysis by project code shows that 54.6 percent of individuals received services in the category of Child and Family Intervention, while 30.26 percent received Mobile Crisis services. While residential services received 16.9 percent of the 2002/03 annual funding, they served only 2.3 percent of total individuals served (or 3.7% if access statistics are excluded).

PERCEPTIONS OF THE CHILDREN'S SERVICE SYSTEM

The next step involved finding out about people's experience with the service system. This entailed gathering information about people's perceptions, observations and opinions. Several methods were used to capture the experience of users, providers and other stakeholders and key informants in the system. Telephone surveys as well as printed questionnaires were supplemented by focus groups and telephone interviews in order to ensure, not only that a broad and representative range of views were elicited, but also that the responses were interpreted correctly in an unbiased manner. The following nine major themes emerged:

Resources

Lack of funding is a major area of concern, exacerbated by competition with mandated services such as child welfare. Additional funding is necessary to enhance services.

Collaboration

Increased linkages between agencies, Ministries, and service sectors are needed to improve service coordination and continuity. Transitional planning between children's and adult mental health services was specifically identified as an area that needs improvement.

Psychiatric Services (Inpatient and Outpatient)

Psychiatric services are the most frequently identified future priority. Additional psychiatrists need to be recruited to Niagara. Likewise, psychiatric and mental health beds need to be available within Niagara's hospitals.

Residential Treatment

There is a lack of regionally based residential resources in Niagara. Enhancing residential services is seen as a future priority and suggestion for system improvement.

Access to Services

Transportation and the geographic location of services were perceived as the two greatest barriers to service. Consumers have difficulty accessing services, as Niagara lacks a regional public transportation system.

Service Gaps

The supply of children's mental health/counselling services in general is outstripped by the demand, resulting in substantial waitlists. Further, there is a need for more specialized supports, e.g., dual diagnosis, autism.

Human Resource Shortages

Recruitment and retention of qualified, trained staff is a problematic issue, due in part to lower salaries. In addition, elevated caseloads lead to staff burnout.

Early Intervention and Prevention

Increased early intervention and prevention programs are needed.

Duplication

Greater clarity is required between Niagara Child and Youth Services and Contact Niagara regarding access and planning functions.

The input from families, service providers and key informants pointed to the following conclusions with regard to the strengths, weaknesses and pressures of the current service system:

- The major strengths are: the quality of existing services and staff; the dedication, flexibility and responsiveness of service providers; families' satisfaction with the access process and with the appropriateness of referrals; the positive impact of services; collaborative service delivery; and strong partnerships.
- Weaknesses include: inadequate levels of service; service gaps and restrictions; inadequate financial and human resources; problems with the timeliness of services due to long wait lists; and fragmentation in the service system.
- Gaps in residential services, counselling, assessment/diagnosis and psychiatric services were identified.
- Obstacles and barriers to accessing services include: the geographical location of services and/or lack of transportation; consumers' out-of-pocket expenses; and problems with taking time off work or school because of the hours that services are offered.

- Insufficient financial resources, competition between agencies and sectors for funding, and a shortage of human resources were seen as key pressures or threats on the system.

It was suggested that priorities for enhancements over the next three years should be: psychiatric services, residential services, assessment and diagnostic services, and counselling.

The opportunities identified for achieving positive change within the Niagara children's system include: increased collaboration; expanding services to meet needs; the potential for more funding and policy initiatives under a new government; and greater coordination of services at the local, regional and provincial levels.

VISION FOR NIAGARA'S CHILDREN'S MENTAL HEALTH SERVICES

The next step in the community planning process was to create a vision, strategic directions, goals and priorities for the next three years. This process was guided by a Reference Group comprised of 16 people, including one consumer, together with senior managers and board members of MCSS/MCYS and related agencies.

After reviewing the information gathered in the community planning process and considering the issues in a series of workshops, the Reference Group developed a draft vision and strategic directions. Feedback was provided through community consultation sessions and a revised vision, strategic directions, goals and priorities were formulated on the basis of this input.

First principles were established for children's service system as follows:

Strengthen the status quo – Enhance positive outcomes for children and families by envisioning a system of children and youth mental health services within an integrated sector; reviewing available data; strengthening and augmenting existing services and developing and implementing new services.

In the allocation of Children's Services Resources in Niagara region we will seek to provide the most complete range of services along the promotion/prevention – treatment continuum.

The Reference Group adopted the following vision statement for the children's services system:

Niagara Region's Children, Youth, and Families are provided with timely and effective mental health services that reflect a coordinated, inter-

ministerial approach, use best practices, and respond to current and emerging needs in the context of the broader community.

A set of six strategic directions was established and a series of goals developed in conjunction with each of these directions. The directions and goals are set out in the following table which also notes the priority of each goal in terms of the year in which it should be implemented.

Strategic Directions and Goals Niagara CHILDREN'S MENTAL Health Services	
STRATEGIC DIRECTION: A FULL SPECTRUM OF MENTAL HEALTH SERVICES FOR CHILDREN, YOUTH AND FAMILIES	
Goal Area: Residential Services	
Work with other communities within Hamilton-Niagara region to develop specialized residential services.	Year One
Increase Niagara's local residential capacity to meet the needs of the children of Niagara	Year One
Explore the feasibility of establishing permanent residential treatment beds in Niagara using fee for service residential dollars	Year Two
Goal Area: Counselling	
Increase the capacity of counselling services in Niagara.	Year One
Goal Area: Psychiatric Services	
Increase the level of psychiatric services so that it meets at the least, the minimum provincial benchmark for a community the size of Niagara.	Year One
Goal Area: Cross Sectoral Supports/Services	
Ensure cross sectoral supports/services are in place to address the mental health needs of families and caregivers.	Year One

Strategic Directions and Goals Niagara CHILDREN'S MENTAL Health Services	
Goal Area: Transitional Age Youth	
Identify and implement best practices related to cross-sectoral transitional age services.	Year Two
STRATEGIC DIRECTION: INFORMATION SUPPORTIVE OF SUCCESSFUL PLANNING AND PROGRAM DEVELOPMENT	
Goal Area: Informed Picture of Services and Gaps	
Develop an informed picture of service gaps and priorities to access and influence new funding, and influence its direction. This includes determining geographical location of needs and preparing an inventory of all current services (including French Language Services), identifying gaps and overlaps in current services.	Year One
Using data from common assessment/baseline tools, undertake research to further understand needs and enhance community planning.	Year Three
Goal Area: Coordinated Service Access	
Assess the location of services, location of clients, service delivery models and transportation needs, and explore alternative methods of providing interagency coordination across Niagara.	Year Two
Goal Area: Community Service Plan Impact	
The MCSS/MCYS Hamilton-Niagara Regional office will take into account Niagara children's mental health community service plan to inform funding decisions.	Year One
Goal Area: Youth Justice Legislation Impact	
Examine the impact of youth justice legislation on other programs (e.g. residential services).	Year One
STRATEGIC DIRECTION: EFFECTIVE USE OF TECHNOLOGY IN MANAGEMENT AND SERVICE DELIVERY	
Goal Area: Information and Technology /Systems	

Strategic Directions and Goals Niagara CHILDREN'S MENTAL Health Services	
Identify what is required from a technology perspective to generate child specific information that can be shared across sectors.	Year Three
Identify opportunities to link the current information systems to enhance individualized planning.	Year Three
Promote the need for a common information system for all children's services with the provincial government.	Year Three
STRATEGIC DIRECTION: CONTINUOUS IMPROVEMENT THROUGH INTER-AGENCY COLLABORATION	
Goal Area: Common Assessment/Baseline Tools	
Reach agreement across all children's service providers on the use of common assessment/baseline tools for children's mental health.	Year Three
Goal Area: Mutually Supported Planning and Decision Making	
Develop an inter-agency approved and provincially sanctioned process/mechanism to facilitate efficient, collaborative, mutually supportive planning and decision making on an ongoing basis.	Year One
Goal Area: Increased Psychiatric and Psychological Supports and Services	
Work together to develop a recruitment strategy that results in increased psychiatric and psychological supports and services in Niagara Region	Year Two
Goal Area: Coordinated Services to Address Pervasive Developmental Disorders	
Coordinate across service sectors to meet the needs of children and youth with pervasive developmental disorders (autism spectrum disorders).	Year One
Goal Area: Coordination of French Language Services	
Increase capacity of children's mental health services to the French community through collaborative work between Centre de sante communautaire and other children's agencies.	Year One
Develop protocols to ensure coordination of French language services in Niagara.	Year One
Goal Area: Ongoing Learning	
Develop formal and informal linkages between children's mental health agencies and centres of research and learning.	Year Two

Strategic Directions and Goals Niagara CHILDREN'S MENTAL Health Services	
Goal Area: Maximize Best Practices	
Collaborate across agencies and sectors to identify/share strategies, results and related outcome measures used by each agency, to maximize best practices.	Year One
STRATEGIC DIRECTION: ACCESSING INFORMATION ABOUT CHILDREN'S MENTAL HEALTH SERVICES	
Goal Area: Informed Client /Families	
Develop communication tools that provide an integrated perspective to clients regarding children's mental health services in Niagara	Year One
Develop and implement public awareness strategies to better inform parents about transitional issues.	Year Two
STRATEGIC DIRECTION: SUSTAINABLE FUNDING	
Goal Area: Multi-Year Funding	
Develop a strategy to influence government policy toward multi-year funding.	Year One
Goal Area: Increased Funding	
Advocate for increased funding to base budgets to address identified mental health needs in Niagara	Year One
Advocate for increased funding to meet the needs of the Youth Justice Act.	Year One
Goal Area: Funding Reflective of Niagara's Determinants of Health	
Advocate for planning and allocations that take into account Niagara Region's determinants of health in addition to child population statistics.	Year One

CONCLUSIONS

The completion of this community service plan represents the fifth and final step in an extensive and inclusive process that involved fact finding, community consultations, analysis of information from multiple sources and the far-sighted deliberations of Reference Group members who brought all this together by creating a vision, strategic directions and goals.

It was always envisaged that this plan would be a starting point. The information collected and the conclusions reached will not only serve to guide the service system over the next three years, but also provide a baseline for future planning endeavours. The process as a whole can also serve as a learning experience, as the community looks for ways of improving upon the information gathering, consultation and consensual decision-making approach that went into developing this plan.

The vision and strategic directions that were created through this planning process are comprehensive and inclusive. They involve extending the reach of the service system to respond to a wide range of community needs. They are also designed to build the capacity of the service system with better data, improved practices, enhanced opportunities for collaboration, and stronger links with the broader community and other service sectors.

The task that lies ahead for all involved is to continue working together to make this vision a reality. The completion of this plan is not the end, but only a beginning.

Part One:

Introduction and Background

OVERVIEW

This community service plan is the result of a community-wide process designed to assist the Hamilton Niagara Regional Office of the Ontario Ministry of Community and Social Services (MCSS) and the Ministry of Children and Youth Services (MCYS) in future resource allocation decisions. It is also anticipated that the plan will assist community agencies and boards of directors in collective goal setting and future community planning processes. Created with input and participation from providers and users of services, as well as other key stakeholders, the plan draws upon quantitative data collected on the community, the current service system and usage, as well as qualitative information about stakeholders' perceptions of the system gathered through surveys, focus groups and interviews. The plan details a shared vision, strategic directions, goals and a set of priorities for the next three years, formulated by a reference group comprised of key stakeholders.

The plan was conceived with the understanding and expectation that community planning is an ongoing process that takes place in an ever-evolving context. It is therefore envisaged that this is just the first of many three-year plans. The recommendations of this plan, as well as the process by which they were achieved, will likely be carefully considered and assessed, not only in implementing this plan, but also in going ahead with future planning exercises. This document therefore describes the planning process, as well as its outcomes. It also provides background information and explanations to put the findings into context for readers who may or may not have a detailed knowledge of the community and workings of the service systems described.

BACKGROUND AND FIRST STEPS

The Hamilton Niagara Regional Office of the Ministry of Community and Social Services (MCSS) and the Ministry of Children and Youth Services (MCYS) is currently responsible for programs under the jurisdiction of both ministries. These programs include children's mental health services that are delivered by five community agencies in Niagara and directly funded by the two ministries.

The Regional Office and the local service community are committed to a systems approach to managing resources in these sectors. This involves focusing upon the relationship between all the people requiring service and all the resources that are available within the system to respond to those needs. The principal goal is to bring about the best match between those defined needs and resources.

An important element of this approach is the capacity for system accountability, whereby agencies regard themselves as components of a system of service and are willing to take collective responsibility for the way resources are used, the results they achieve, and the way consumers experience the system. This approach to service system management requires community-based planning processes that can provide information to ensure the best use of available resources and to assist in determining where and how to allocate new resources, when it is possible to do so.

To this end, in December 2001, the Regional Office initiated a process for the development of community service plans for both the children's and developmental services sectors in each of the four communities that comprise the Hamilton Niagara Region. The responsibility for initiating and leading this process was placed in the hands of the four Contact agencies – Contact Hamilton, Contact Brant, Contact Niagara and Contact Haldimand-Norfolk – that serve as the single point of access to children's and developmental services in each community.

The Contact agencies in Hamilton, Brant and Niagara were established in 1999 and Contact Haldimand-Norfolk was formed in 2001. The Contact agencies were established as a response to a 1997 policy directive referred to as "Making Services Work for People." This policy challenged communities to come up with solutions to make the service delivery system more responsive to the needs of individuals. Subsequent community consultations revealed that many people found the social service system confusing, fragmented and hard to navigate. The Contact agencies were created as single points of access for people seeking children's and developmental services. Their role is to provide information about the programs and services offered by the Ministry-funded children's and developmental services agencies, while acting as a central intake point for these services. They also facilitate resolution processes to help people with particularly complex or urgent needs who are having difficulty getting the required support.

The mandate of the Contact agencies also requires that they play a role in planning and coordinating services in the children's and developmental services sectors – the two sectors to be included in the Hamilton Niagara Region community service planning process. The prime focus of the Contact agencies and of this planning process is also on services directly funded by the Ministry of Community and Social Services and the Ministry of Children and Youth Services rather than programs and services that get their funding from other sources.

The children's services delivered through Ministry-funded agencies provide support to children, youth and their families who are experiencing behavioural, emotional, social or developmental concerns. These are non-mandatory services, as distinct from services that are mandated such as the young offender or child welfare systems. The services include assessment, individual therapy, family therapy, residential treatment, group therapy, intensive child and family intervention, crisis response services and respite services.

As a first step in the planning process, the Regional Office asked the Contact agencies to develop a framework and methodology in consultation with service providers, related service sectors and consumers. It was envisaged that the access role played by the Contact agencies would in itself produce significant information regarding service gaps, pressures and trends, while this would be supplemented through input from service providers and consumers. In a December 21, 2001, memo to service providers, the Regional Office strongly encouraged the involvement of providers and also stressed the importance of client and family input into the development of the plans.

Designing the framework and methodology would in itself be a significant planning exercise. In its memo, the Regional Office laid the groundwork for this "plan to plan", stipulating that it should involve the following elements:

- Identification of key stakeholders
- Building consensus and support for the planning process
- Developing consensus on the required data and common tools to be used in the ongoing development of the plan
- Developing a template for the community service plan and the process.

PLANNING TO PLAN

While individual community service plans would eventually be created for different communities and sectors, it was agreed that a common planning framework and methodology would be developed through a region-wide process. The four Contact agencies contracted with Human Services Consultants to assist in accomplishing the four tasks that the Regional Office had identified as key steps in this process.

The Contact agencies took a three-phase approach to this exercise of “planning to plan.” The first phase consisted of an initial round of individual meetings between the project consultant and 24 key informants across the four jurisdictions. The purpose of these meetings was twofold. First, to discuss any unique local characteristics that might need to be considered in the design of the approach to community service planning. Second, to elicit ideas that might help clarify the content, process, and participants for the next phase of the project. The individual interviews took place from late February to mid-March of 2002.

The second phase of the consultation consisted of holding sixteen focus groups across the four jurisdictions. Participants in the focus groups represented a cross-section of perspectives, including consumers, board members, service providers, and others such as planners and funders. In all, 146 people participated in the focus groups. The sessions began with a brief overview of the project and the proposed steps, content, and guiding principles for community service planning. The groups then discussed each component of the proposal in turn, recording their views on the merits of the proposal at the end of each discussion.

Although the comments from the focus groups were supportive of the proposed approach, they also included a number of specific suggestions which led the Contact agencies to reconsider and revise the proposal in a number of ways. These revisions were presented at five information sessions. The sessions began with a review of the original proposal, followed by a summary of the findings from the focus groups. This was then followed by a presentation of the revised proposed approach and a summary of the Contact agencies’ recommendations to the Regional Office.

The proposal that emerged was for a community service planning process that would be comprised of the following five steps, as outlined in the Contact agencies’ July 2002 summary report:

Step One: Collecting Information on Patterns

This first step was designed to provide a good descriptive overview of the relationship between population variables, the current service system, use of resources, pressures on the service system, and broader contextual considerations.

Step Two: Collecting Information on Experience

This would involve collecting information about people’s experience with the service system. This information would be more personal and subjective than that gathered through Step One, but equally important. Since different constituencies experience the system in different ways, information would be collected from at least five perspectives:

- People requesting service
- People receiving service

- Community groups and organizations
- Providers of Ministry-funded children's and developmental services
- Providers of related services.

Step Three: Collating and Analyzing Information

The findings from the first two steps would then be collated and analyzed with regard to a number of themes:

- Perceived strengths or opportunities within the service system
- Perceived gaps or duplications
- Issues and/or barriers related to the availability or delivery of services
- Views regarding priorities for service
- Potential trends in a variety of areas relevant to planning

It was proposed that the Contact agencies would be supported and assisted in this task by a Technical Advisory Group, comprised of a small number of external experts in information collection and analysis. This group would assist in the design of the information collection tools and methodology, provide advice on the quality and consistency of the information collected, and oversee the collation, interpretation and analysis of the findings.

Step Four: Developing a Vision and Priorities for the Next Three Years

The objective of this step would be to create a shared vision and set of priorities for the children's and developmental services system for the next three years. A three year time-frame was chosen as a compromise between short and long-term planning, to encourage people to think about the future without it being so distant that the exercise would be unrealistic.

The focus of the visioning and priority-setting process would initially be on the local system of children's and developmental services, and then expand to address linkages to other local services and to Hamilton Niagara Regional services. The three-year vision should build on the findings from the previous steps in the process, describe a future continuum of children's and developmental services, and describe the desirable characteristics of this service continuum (e.g. ability to measure outcomes, reduction of waiting periods, high levels of consumer satisfaction).

In order to develop a shared vision with broad support, it was proposed that "visioning groups" (later to be described as "reference groups") be established. These groups would be comprised of individuals representing a broad cross-section of perspectives who would be willing to review the findings from the earlier stages of the process and be committed to operating within the framework of the community service planning process.

Once the visioning group had developed a proposed vision and set of priorities, a series of community consultations with groups and organizations would be held. The findings from this consultation process would then be reviewed by the visioning groups for possible revisions to the proposed vision and priorities.

Step Five: Complete Community Service Plan

The final step would involve completion of the community service plan itself. It was suggested that the content of the plan should begin by reflecting the findings from the first four steps. That is, it would contain summaries of the findings related to patterns and experience; summaries of the perceived strengths and opportunities, gaps, duplications, issues and barriers, priorities and trends; and a description of the vision and priorities for the next three years. In addition, it should include priorities for the next year for the local service system and its linkages with the larger Hamilton Niagara Regional service system.

The "Plan to Plan" project also proposed a set of guiding principles that were considered essential to carrying out a credible and comprehensive community service planning process. These were as follows:

- Focus on the whole and the way the parts contribute to the whole (system focused)
- Strive to hear diverse perspectives and to customize approaches (inclusive process)
- Base each step on the findings from previous steps (findings based)
- Keep the emphasis on achievable change (realistic planning)
- Seek feedback from participants and try to continually improve the community service planning process (continuous improvement).

ISSUES AND CHALLENGES

The 'Planing to Plan' process identified a number of challenges and concerns that would likely emerge as the community service planning process unfolded. These included a number of issues involving what the community would expect from the process, as well as some concerns about how information could be collected.

With respect to community expectations, four themes had emerged from the focus groups. These had to do with the scope of community service planning, whether it is about growing or changing the service system, the extent to which it should be focused on tasks versus process, and the need for acceptance that it will be a developmental process.

Questions about the scope of the planning process were raised during the focus groups, with some participants suggesting that the scope should be broader than those of the two

sectors that come within the mandate of the Contact agencies. There were also discussions about whether the children's and developmental services sectors should be considered in separate or combined community service plans. The recommendations that emerged from the 'Plan to Plan' process suggested that a combined approach would be appropriate for Haldimand-Norfolk, while other jurisdictions in the Hamilton Niagara Region should plan services in each sector separately. In response to suggestions that the scope of the planning be broader, it was noted that the request from the Regional Office was to begin with a focus on these two sectors with the inclusion of the sectors that provide services and support to children and individuals with developmental disabilities.

It was clear from comments during the focus group sessions that some participants saw community service planning as mostly about setting priorities for new resources (i.e. growing the service system), while others saw it as an opportunity to rethink the current use of resources (that is, changing the system). The July 2002 summary report noted, however, that the process is, in fact, about both, and the two expectations should not be viewed as mutually exclusive. However, the report suggested that it is important to get the message across that the community service planning process includes the license to rethink the use of existing resources, so that participants in the planning process understand that the exercise makes no assumptions about the merits of the current design of the system.

The consultation also revealed a tension in expectations about process and action that is common in any planning process. Some people put a high priority on getting things done quickly, while others put a premium on being inclusive and taking the time to build consensus. This means, the summary report noted, some will be frustrated that the community planning exercise doesn't put enough emphasis on action, while others will be frustrated that it isn't sensitive enough to process and/or the inclusion of all interested parties. While these need not be mutually exclusive expectations, the Contact agencies should strive to find a balance between process and action that keeps most people satisfied with the overall exercise, the July 2002 report concluded.

Also identified in the July 2002 report was a concern about the high expectations that people would have for community service planning, both in terms of the quality of the process and of the value of the plan itself. Even though everyone involved presumably wants the process to be credible and useful, it needs to be kept in mind that community service planning is a new and complex venture, and that there is no instruction booklet on how to do it well, the report cautioned.

"As with any new venture, there are apt to be some false starts and mistakes made along the way. Those involved in the process will need to recognize its developmental nature, and be patient and accepting as lessons are learned and the process matures. Both the Regional Office and the Contact agencies can reinforce this message by being direct about the developmental nature of the process," the report suggested.

The report noted that one of the biggest operational challenges in implementing the proposed community service planning approach would be the collection of good information. Three reasons were cited for this. The first was that the field lacks consistent definitions for describing consumer characteristics and service-related functions. The second was that it also lacks consistent categories for classifying types of services and counting units of service. The third was that there is a whole cluster of issues associated with the availability of data, such as whether the desired information is currently being collected and whether it can be readily retrieved, whether it is collected in such a way as to be useful to the community service planning process (for example, whether it is collected as part of a larger data set that cannot easily be separated to provide information about specific local services).

A concern that followed from all these considerations was one of timing. The report noted that it would take the Contact agencies some time to develop the consistent definitions and categories, as well as to design and create the necessary information systems to store and retrieve information and data. With this suggested the report concluded that not all the desired information and data would be available in the first planning cycle.

THE DESIGN

In November 2002, the Regional Office approved the design recommended in the July 2002 Summary Report. It was agreed that the community service plans would be developed through the five-step process, as outlined, with the assistance of a Technical Advisory Committee. The Regional Office supported the concept of developing a shared vision and reiterated its desire to encourage broad stakeholder participation in this process. It endorsed the concept of three-year plans that would be renewed every three years. It stipulated that the plans should focus primarily on Ministry-funded services, but would naturally take into account relevant issues/activities in other sectors that are influenced by or have influence upon this service delivery system.

The Regional Office also stressed that the plans need to address both how new resources ought to be prioritized and allocated, as well as examine redeployment of existing resources to better meet identified priority needs in the community. Since the volume, scope and timing of new resources cannot be predicted, service planning must always re-examine the best use of current funding, stated a memo to Contact agencies from the Regional Office.

In approving the Contact agencies' design recommendations, the Regional Office reiterated an earlier statement: "We can commit to considering very carefully the contents of the community service plans, discussing the potential of these reports with all key stakeholders and using key service data to advance the legitimate interests of this Region.

We are optimistic that these plans will position the Region to capitalize on opportunities for investment and/or reinvestment in a manner not currently available.”

IMPLEMENTING THE DESIGN

In order to move on to the next stage – developing community service plans for the different communities and sectors – the Contact agencies contracted with Human Resources Consultants to provide overall project coordination and formed a project management team comprised of the consultant and representatives from each Contact agency. This team developed an approach to implementing the agreed-upon planning design, addressing common elements of the four community planning processes, including methodology, tools and timelines.

To assist with the information collection and analysis steps in this process, and in keeping with the approved design, a Technical Advisory Group was formed. This was comprised Dr. Michael Boyle and Anne Ehrlich of McMaster University, Rita Marie Hadley of the Grand River District Health Council and Don Jaffray of the Hamilton Social Planning and Research Council. Its role was to provide the project management team with advice on the design of the approach to information collection and on the analysis and interpretation of findings.

An Information Collection Framework was designed that specified what data should be collected from which sources and how it could be obtained.

It was agreed that the collection of quantitative information would include:

- A review of census data to profile each local community
- A review of service contracts to describe the current children's and developmental services sectors
- A review and analysis of service request and usage data collected from Contact agencies and other sources
- An agency questionnaire to collect information on people currently receiving services and supports in the two sectors

This quantitative data would be supplemented by qualitative information, including:

- Telephone surveys of individuals and families in each of the four jurisdictions to elicit their experience with the service system
- Questionnaires for community groups and organizations, and providers of Ministry-funded and related services to identify perceived strengths, gaps, and other characteristics of the current service system

- Focus groups with individuals and families, community groups and organizations, and providers of Ministry-funded and related services to further explore perceived strengths, gaps, and other characteristics of the current service system
- Key informant interviews to describe important contextual factors that should be considered during the later visioning and priority-setting part of the process

The project team and the technical advisory group also formulated a set of seven questions that the research and community planning process should address:

1. What is the nature and magnitude of the demand for Ministry-funded service and supports within a jurisdiction?
2. What resources are available to respond to that demand and how are they currently being used?
3. What are the identified strengths, weaknesses and pressures of the current service system?
4. What should be the priorities for enhancing the current service system over the next three years?
5. Where are the opportunities to address population well-being and achieve positive change within the current system?
6. What are the characteristics of the local community that need to be taken into account when planning?
7. What areas require further exploration?

After a tendering process, the consulting firm Shercon Associates Inc. was contracted to carry out the information collection and analysis steps for each of the four jurisdictions. Shercon began working on the project in August 2003.

The methodological components of the data collection process that formed the next stage of the project are mapped against specific groups and data sources in the table below.

Table 1: Methodology

GROUP	METHOD	DATA
Families and Individuals	<ul style="list-style-type: none"> • 400 phone interviews – 100 in Niagara • 6 focus groups - 2 in Niagara 	Experiences with the system
MCSS / MCYS Funded Agencies	<ul style="list-style-type: none"> ▪ Data collection template, ▪ Ministry service contracts 	Intake and activity
Service Providers and Community Groups	<ul style="list-style-type: none"> • 203 completed questionnaires (region-wide) • In Niagara: <ul style="list-style-type: none"> • 28 questionnaires from 25 children's agencies 	Perceptions of the system

GROUP	METHOD	DATA
	<ul style="list-style-type: none"> • 17 questionnaires representing 10 agencies for developmental services (response rate 81%) • 6 focus groups region-wide 2 focus groups Niagara 	
MCSS / MCYS	<ul style="list-style-type: none"> ▪ Review of service contracts 	Resource and activity levels
Government and Associations	<ul style="list-style-type: none"> ▪ 10 key informant interviews 	Contextual information
Planning Bodies	<ul style="list-style-type: none"> ▪ Review of reports and census data 	Community characteristics
Contact Agencies	<ul style="list-style-type: none"> ▪ Review of data systems, BCFPI, Performance Measurement Survey 	Usage rates, satisfaction

Part Two:

Niagara Community Profile

OVERVIEW

With a population of 410,575, the Niagara Region occupies a 1,896 square kilometre peninsula bounded by the City of Hamilton to the west, Lake Ontario to the north, Lake Erie to the south and the Niagara River that marks the U.S. border to the east. Its two-tier local government structure is headed by a regional council comprised of representatives from twelve local municipalities: Grimsby, Lincoln, St. Catharines, Niagara-on-the-Lake, West Lincoln, Pelham, Thorold, Niagara Falls, Welland, Wainfleet, Port Colborne, and Fort Erie.

Niagara's most heavily populated cities of St. Catharines, Niagara Falls and Welland contain 62 percent of the region's population. Much of the remainder of the region is rural, though there are several other urban areas, widely dispersed around the peninsula, including Fort Erie, Port Colborne, Grimsby, Thorold and Niagara-on-the-Lake.

It is a region that boasts one of the world's greatest tourist attractions in Niagara Falls and attracts millions of visitors every year, who are also drawn to the region's wineries and other tourist attractions, such as Niagara-on-the-Lake's Shaw Festival theatres. The tourism, retail and service sectors therefore loom large in the region's economy. The Welland Canal and bridges that provide access to the United States give the region a pivotal role as a transportation hub, while a large portion of the workforce is employed in manufacturing and telecommunications. Agriculture is also a significant industry in a region noted for its vineyards and fruit growers. The diversity of the region's economy is

illustrated by the fact that Niagara's four largest employers (each of which has more than 3,700 employees – at least 1,300 more than the fifth largest employer) are: General Motors of Canada Ltd., the District School Board of Niagara, the Niagara Health System and Casino Niagara.

POPULATION AND GROWTH

As can be seen from Table 2, the population of the region increased 1.8 % from 1996 to 2001, which is less than the provincial increase of 6.1%. However, rates of growth varied within the region from one municipality to another. There was relatively high growth in Lincoln (where the population increased by 9.6%) and Grimsby (with an 8.7% increase). Growth in Pelham and West Lincoln kept pace with that of the province as a whole, while Niagara-on-the-Lake, Fort Erie and Niagara Falls experienced more modest growth. Thorold grew by only 1 percent, while Welland, Port Colborne and Wainfleet had no growth. The population of St. Catharines declined by 1.3 percent.

Table 2: Population by Geographic Distribution, 1996-2001

Jurisdiction	Population		Increase (%)
	1996	2001	1996-2001
Region of Niagara	403,504	410,574	1.8
Fort Erie	27,183	28,143	3.5
Port Colborne	18,541	18,450	0.0
Wainfleet	6,253	6,258	0.0
West Lincoln	11,513	12,268	6.6
Pelham	14,343	15,272	6.5
Welland	48,411	48,402	0.0
Thorold	17,883	18,048	1.0
Niagara Falls	76,917	78,815	2.5
Niagara-on-the-Lake	13,238	13,839	4.5
St. Catharines	130,926	129,170	-1.3
Lincoln	18,801	20,612	9.6
Grimsby	19,585	21,297	8.7
Ontario	10,753,573	11,410,046	6.1

Source: Statistics Canada, 2001 Census

Projected growth for the Region over the five years from 2003 to 2008 is expected to be 3.1 percent, which is less than the 4.3 percent projected for the Hamilton-Niagara Region and considerably less than the provincial growth projected to 2008 at 8.5 percent.

Table 3: Projected Population by Geographic Distribution, 2002-2008. Population in thousands (with annual percentage increases)

Jurisdiction	2001	2002	2003	2004	2005	2006	2007	2008	% Var
Niagara	410.5	412.4 (.4%)	414.3 (.4%)	416.2 (.4%)	418.1 (.4%)	420.0 (.4%)	421.8 (.4%)	423.7 (.4%)	3.1
Ham/ Niagara	1,137.0	1,144.1 (.06%)	1,151.4 (.06%)	1,158.6 (.06%)	1,165.9 (.06%)	1,173.1 (.06%)	1,179.7 (.05%)	1,185.9 (.05%)	4.3
Ontario	11,410.0	11,546.9 (1.2%)	11,685.5 (1.2%)	11,825.7 (1.2%)	11,955.8 (1.1%)	12,087.3 (1.1%)	12,220.3 (1.1%)	12,345.7 (1.1%)	8.8

Source: Statistics Canada, and Projections for the Ministry of Finance. Percentages have been rounded to one decimal point; therefore there will be minor differences.

Niagara's moderate climate and other assets make it an attractive retirement destination and its population therefore tends to be older than that of the rest of the Hamilton Niagara Region and the province as a whole. In fact, a recent Ontario Ministry of Finance comparison of census metropolitan areas (which are urban areas defined by census divisions, not municipal boundaries) found that the St. Catharines-Niagara area has the oldest age structure of any census metropolitan area in Ontario. The Ministry of Finance demographic trend report also notes that the St. Catharines-Niagara area has the lowest share of children and young people aged under 25 and adults aged 25 to 54.

As the following table shows, in 2001, Niagara residents aged 65+ constituted 16.2 percent (69,426) of Niagara's population, 3.5 percent higher than the provincial average of 12.7 percent. Within Niagara, with the exception of West Lincoln and Wainfleet, all municipalities had a higher proportion of their population aged 65+, compared to the provincial average.

Table 4: Population Distribution and Age Cohorts

Age Group	Niagara		Hamilton Niagara Region		Ontario	
	Total	%	Total	%	Total	%
0 to 14	76,619	18.0	217,787	18.7	2,268,242	19.2
15 to 24	55,313	13.0	155,151	13.3	1,550,100	13.1
25 to 44	121,858	28.6	343,964	29.5	3,738,930	31.6
45 to 64	103,139	24.2	275,479	23.6	2,758,261	23.3
65 to 74	36,832	8.6	92,456	7.9	828,389	7.0
75 to 84	25,248	5.9	62,820	5.4	512,028	4.3
85+	7,346	1.7	18,640	1.6	160,232	1.4
Total	426,355	99.6	1,166,297	100	11,816,182	99.9

Source: Statistics Canada 2001 census—Percentages have been rounded to one decimal place; therefore there will be minor variances

The population of children 0-6 years was expected to decline in 2003, then grow slowly, but steadily through 2010, according to the Early Years Steering Committee Niagara's March 2002 report *Strengthening Tomorrow: A Community Action Plan*.

The birth rate, shown in the following table, is higher for all age groups (15-19, 20-24, and 25-34) than the provincial rate, except for 35-44 year old women where it is considerably less. The highest birth rate is in Grimsby.

Table 5: Age-specific Live Births - Estimated Annual Rate per 1000 Females, 1997- 1999

	15-19	20-24	25-29	30-34	35-39	40-44	TOTAL
Fort Erie	22.89	71.62	103.33	70.98	24.07	4.52	45.72
Grimsby	7.63	40.79	127.74	114.39	41.79	4.78	52.07
Niagara Falls	23.66	53.39	107.00	81.86	28.92	3.52	48.63
St. Catharines	17.83	54.35	97.90	83.36	34.75	5.18	48.65
Welland	23.32	63.98	102.60	73.44	20.55	3.53	46.12
Niagara Region	18.00	55.52	106.27	85.04	29.46	4.1	47.73

Source: Niagara Public Health Department

IMMIGRATION AND MINORITIES

Immigration trends are also an important factor to consider in community service planning, not only because they affect the overall growth of the population, but also because the language that people speak, as well as their cultural background, may well be relevant to the type of services they need and how they can best be delivered.

The population of Niagara is less ethnically diverse than the rest of the Hamilton Niagara region and the province. An analysis of the immigration figures shown in Table 6 below indicates that the proportion of foreign born people in Niagara's population is slightly lower than that of the Hamilton Niagara region as a whole and substantially lower than that of the province as a whole (the actual percentages – not shown on the table – are 17.7% foreign born in Niagara, 19.7% in the Hamilton Niagara region and 26.8% in Ontario). Table 6 also shows that foreign-born people who immigrated between 1991 and 2001 make up only 2.5 percent of Niagara's population, compared to 3.9 percent of the population of the Hamilton Niagara region and 9.0 percent of the Ontario population.

Within Niagara, recent immigrants have tended to settle in the largest city St. Catharines and near the U.S. border in Niagara Falls and Fort Erie, while Welland and Grimsby attract far fewer immigrants.

Table 6: Population by Geographic Distribution and Recent Immigration

	# of people answering census question on immigration	Canadian born population	Foreign-born population	Immigrated 1991- 2001	% pop. recent immigrants 1991-2001
Niagara	404,590	331,560	71,200	10,365	2.5
Fort Erie	27,830	23,106	4,560	890	3.1
Grimsby	20,940	17,295	3,565	400	1.9
Niagara Falls	78,015	62,310	15,430	2,800	3.5
St. Catharines	126,875	100,235	25,805	4,345	3.4
Welland	47,705	41,670	5,900	755	1.5
Hamilton Niagara Region	1,108,960	848,025	218,055	43,955	3.9
Ontario	11,285,550	8,164,860	3,030,075	1,022,370	9.0

Source: Statistics Canada 2001 Census—Percentages have been rounded to one decimal place; therefore there will be minor variances.

Twenty-three percent of Niagara's immigrant population was born in the United Kingdom, 15 percent in Italy, 8.9 percent in the United States, 10 percent in Germany or Poland, 7.8 percent in the Netherlands, and 2 percent in each of Yugoslavia, Croatia, Ukraine, and Hungary, according to the Niagara Early Years Steering Committee Report.

In the 2001 census, 81 percent of Niagara respondents reported English as the language most often spoken at home and 3.5 percent reported speaking French at home. This compares to 70 percent who reported English as their home language across the province, and 79% in the region. Italian, German, Dutch and Polish are the most commonly spoken unofficial languages.

Niagara has two communities designated under the French Languages Services Act – Welland and Port Colborne. In 2001, 5,680 people in Welland (12% of the population) and 1,190 people in Port Colborne (6.6% of the population) reported French as their mother tongue.

Table 7 provides statistics on the languages spoken by Niagara residents.

Table 7: Population by Geographic Distribution and Language Spoken at Home

Language spoken most often at home	Niagara	Hamilton Niagara Region	Ontario
English	328,875	880,630	7,965,225
French	1,250	23,340	485,630
Non-official languages	57,085	193,005	2,672,085
Italian	14,200	36,575	295,200

Language spoken most often at home	Niagara	Hamilton Niagara Region	Ontario
German	8,090	18,680	156,080
Dutch	5,730	12,080	69,655
Polish	4,805	16,905	138,940
Hungarian	2,615	8,240	45,275
Ukrainian	2,520	6,480	48,620
Chinese	1,440	5,855	202,125
Arabic	1,285	6,310	94,635
Serbian	1,125	6,490	32,000
Croatia	1,080	6,690	37,260

Source Statistics Canada: 2001 Census

The population of the Niagara region is very stable in terms of mobility, with nearly two-thirds of the population living at the same address for five years and most of the remainder living at a different address within the province of Ontario. Only 11,730 people in the entire region reported in the 2001 Census that they had lived outside the province or country five years ago.

Table 8: Mobility Rates

Jurisdiction	Total population 5 years and over	Lived at same address 5 yrs ago	Lived in Ontario 5 years ago but changed addresses	Lived outside of province or country 5 years ago
Region of Niagara	382,870	240,925	130,215	11,730
Fort Erie	26,365	16,415	9,015	930
Grimsby	19,785	12,365	7,010	415
Niagara Falls	73,845	46,350	24,905	2,590
St. Catharines	120,075	73,005	42,225	4,840
Welland	45,150	28,305	16,005	840
Ontario	10,609,755	6,067,755	37,784,170	757,830

Source: Statistics Canada, 2001 Census

As Table 8 indicates, most in-migration to Niagara comes from Ontario. According to research conducted by the Early Years Steering Committee Niagara, migrations from elsewhere in the province accounted for 75 percent of new arrivals between 1968 and 2000. The Regional Municipality of Niagara's *Niagara District Health System Monitoring Report 2003* notes that most of these in-migrants are over 45 years of age and are coming from larger urban centres.

Fort Erie is the main port of entry for refugees entering Canada. According to the Fort Erie Refugee centre, 8,695 refugee claims were made there in 2001 (compared to 5,250 refugees who entered Canada via Pearson International Airport). While most refugees eventually move to other areas, Niagara must provide temporary support to them when they are most vulnerable. These refugees often have outstanding mental and physical health issues, a limited knowledge of English and no family or social supports, according to the *Niagara District Health System Monitoring Report 2003*.

EDUCATION

As Table 9 illustrates, education levels in Niagara are very similar to those elsewhere in the Hamilton Niagara region, but significantly lower than those found elsewhere in the province. There are proportionately more people with less than high school education in Niagara than elsewhere in Ontario. In addition, the proportion of the population with post-secondary education is more than seven percentage points lower than the provincial average.

Table 9: Population by Geographic Distribution and Level of Education

Level of Education (age 20-64)	Niagara	Hamilton Niagara Region	Ontario
% Population (20-64 yrs.) with less than high school	21.6	23.3	19.9
% Population (20-64 yrs.) with high school & some post secondary	30.3	28.5	27.2
% Population (20-64 yrs.) with Trades certificate or Diploma	12.7	12.3	10.3
% Population (20-64 yrs.) with Post Secondary education, college or university, certificate, diploma or degree	35.1	35.6	42.5

Source: Statistics Canada 2001 Census—Percentages have been rounded to one decimal place; therefore there will be minor variances

FAMILIES AND FAMILY INCOME

As Table 10 shows, there are 117,185 families in Niagara, close to 90,000 of which are led by married couples, with a further 10,290 led by common-law couples and 17,825 single-parent families. The overwhelming majority of the single-parent families are led by females, though there are 3,215 male-led single-parent families. The pattern is similar to that of the rest of the region and the province.

Table 10: Population by Geographic Distribution and Family Structure

Family Structure (Characteristics)	Niagara (% of Ontario)	Hamilton Niagara Region (% of Ontario)	Ontario
Total # of families	117,185 (3.6)	317,025 (9.9)	3,190,990
# of married-couple families	89,065 (3.7)	238,835 (9.9)	2,406,340
Average # of persons in married couple families	3.1	3.1	3.2
# of common law couple families	10,290 (3.4)	29,130 (9.7)	298,540
Average # of persons in common law families	2.7	2.8	2.7
# lone parent families	17,825 (3.6)	49,055 (10.0)	486,105
Average # of persons in lone-parent families	2.5	2.5	2.5
# of female lone-parent families	14,610 (3.6)	43,380 (10.8)	401,240
Average # of persons in female lone parent families	2.5	2.5	2.6
# of male lone-parent families	3,215 (3.7)	8,880 (10.4)	84,860
Average # of persons in male lone parent families	2.3	2.4	2.5

Source: Statistics Canada 2001 Census—Percentages have been rounded to one decimal place; therefore there will be minor variances

The economic circumstances of these families is clearly a key element to be considered in planning services, not only because income is one of the determinants of health, but also a family's economic situation may affect their ability to access services. For example, a family may find it difficult to pay for transportation costs or be unable to spare the time off work to attend a program.

Employment levels are relatively high in the Niagara region, though the importance of the tourist industry in the regional economy means that unemployment rates are subject to seasonal fluctuations. As of September 2003, Niagara's unemployment rate of 6.1 percent was lower than that of the Hamilton Niagara region as a whole (7.0%) and considerably less than the provincial rate of 7.5 percent.

Nevertheless, median family incomes in Niagara are generally lower than elsewhere in the province. The median income represents the mid-point in all incomes, where half of all households earn more than the median and half earn less. The median is not the same as the average, but it gives a better picture of normal family or household incomes because the average can easily be skewed by the high earnings of a few people.

As Table 11 illustrates, the median income in Niagara for all families is \$56,787 and, for couple families, it is \$61,124. Both of these figures are slightly lower than median incomes elsewhere in the region (shown in Table 11 as an average of the median incomes in each community). However, the median incomes in Niagara, as elsewhere in the Hamilton Niagara region are significantly lower than the median incomes of the province as a whole. The median income for single parent families is marginally higher than the average of medians for the region, but it is still lower than the provincial median.

The highest median incomes are reported in the prosperous commuter community of Grimsby, where the median for all families is 20 percent higher than the Niagara median, while the median for couple families is 15 percent higher and for single parent families 45 percent higher. At the other end of the scale, the median for all family incomes in Niagara Falls is 6 percent less than the Niagara median, while single parent families are 10 percent less well-off in Niagara Falls than elsewhere in the Niagara region.

Table 11: Population by Geographic Distribution and Family Income

Jurisdiction	Median Family Income \$ (all census families)	Median Family Income \$ (couple families)	Median Family Income \$ (lone parent families)
Region of Niagara	56,787.00	61,124.00	32,334.00
Fort Erie	51,395.00	56,279.00	31,018.00
Grimsby	69,181.00	72,300.00	45,380.00
Niagara Falls	53,715.00	59,987.00	29,299.00
St. Catharines	54,775.00	59,539.00	32,479.00
Welland	54,874.00	59,994.00	31,459.00
Ham/Niagara Region (average of medians)	57,305.00	62,041.00	31,676.00
Ontario	61,024.00	66,476.00	33,724.00

Source Statistics Canada—2001 Census

Niagara has a higher percentage of low income families than the province as a whole, according to Statistics Canada census reports. Statistics Canada uses a measure known as “Low Income Cut-off” (LICO) to assess whether families are “living in straightened circumstances.” This measure – which is commonly (though incorrectly, according to Statistics Canada) used as an unofficial “poverty line” – assesses whether households spend disproportionate amounts of their pre-tax income (20 percent more than the average family) on food, clothing and shelter. There are numerous different LICOs for various sizes of community, as well as sizes and types of family.

For example, Niagara Falls is categorized as a community with a population between 30,090 and 99,999. According to the 2001 census information, the average size of single parent families in Niagara Region is slightly less than 3. The median income for single parent families in Niagara Falls is \$29,299.00. The LICO for a 3 person family in a

municipality this size is \$25,505.00, meaning that the average single parent family in Niagara Falls has a median income which is 15% per cent higher than the unofficial poverty line.

According to the 2001 census information, the overall Low Income Cut-off incidence rate for the Niagara region was 13.2 percent compared to the provincial average of 11.7 percent. That is to say that 13.2 percent of all families in the Niagara region had an income below the established LICO rate for their respective community.

The Niagara Region Department of Public Health reports that the region has a higher proportion of people on social assistance than the province as a whole. Citing statistics from the Region's Community Services Department and the Ministry of Community and Social Services, the Health Department notes that 62 people in every thousand Niagara residents were beneficiaries of the Ontario Works or Ontario Disabilities Support Program in 2002, compared to 56 per thousand in Ontario as a whole. As of February 2002, 3,285 of the Region's children aged 0-6 years were members of households in receipt of social assistance benefits, according to the Early Years Steering Committee Niagara.

SUMMARY: CHARACTERISTICS OF THE COMMUNITY

What are the characteristics of the local community that need to be taken into account when planning? That is one of the key questions posed at the beginning of the community planning process and this community profile provides a few of the answers.

Niagara's population is dispersed among several larger urban centres, some smaller towns and rural areas, covering a large geographical area, thus making it difficult to provide services that are equally accessible to all.

The population is growing more slowly than the rest of the province and has a higher concentration of older people, with proportionately fewer children and young people. The birth rate is higher than average, however, it has been projected that the population of children and youth will rise slowly but steadily in coming years.

The community is less ethnically, culturally and linguistically diverse than others in Ontario, though it receives a large influx of refugees at the border post in Fort Erie. Two urban centres – Welland and Port Colborne – have been designated under the French Language Services Act.

Education levels in Niagara are generally lower than elsewhere in the province– a factor that could influence public awareness of services and people's ability to take advantage of them.

The region's economy is diverse and unemployment relatively low, though this fluctuates due to the seasonal nature of the tourist industry. Family incomes tend to be lower than elsewhere in the province. There are more low income people and more people receiving social assistance. These are factors to be considered in planning, not only because low income may contribute to the needs for which families seek help, but also because of its impact on people's ability to access the service system.

Part Three:

The Children's Mental Health Service System

OVERVIEW

Any child growing up today will come in touch with a vast array of community services and programs delivered by different levels of governments and community organizations. They will inevitably be involved in the education system and the health care system. At some point, they will likely benefit from child care, recreation and other community programs. Their well-being will be monitored by child welfare agencies and they could possibly become involved with the youth justice system. Should their families experience financial difficulties they may require the assistance of income support programs. If a child has special needs, there is a whole other set of programs and services available, depending on the particular need of the child and his/her family. Most children at one time or another participate in religious or cultural groups, neighbourhood clubs or associations. Furthermore, children will be impacted by environmental, economic and social decisions made by bodies such as city planners and environmental agencies.

This pattern of connections and interconnections represent the context within which children's mental health services and services for children exist. An ideal planning process would include and characterize all the possible circumstances that impinge upon these specific program areas. But this would be a significant task that is beyond the scope and purpose of this community service plan.

This planning process focuses on a subset of the whole children's service system – the set of specialized children's mental health services that lies directly within the purview of the regional office of MCSS and MCYS. These services and programs, funded through the Ministry of Children's and Youth Services, provide specialized services for children and youth experiencing social, behavioural, emotional and psychological problems.

This section describes the service system based on the data available from existing sources and agency surveys. The purpose is to provide an overview of the Ministry-funded children's service system. It describes how the programs are classified and funded by the Ministry. It identifies which agencies provide the services, who receives them, what their needs are and what types of services are required. It also indicates the extent to which people have to wait to receive service and how urgent situations are addressed.

FUNDING AND PROGRAMS

The Ministry allocates funding to provide specialized services for children and youth experiencing social, behavioural, emotional and psychological problems. This funding for children's mental health services is provided in 11 different categories of programs, each of which is identified with a unique 'project code'. The program categories range from residential services, where children would live away from home to receive the services they require, to services provided in the community, such as counselling and child treatment services. A further category includes services that assess children's and families' needs and refer them to the appropriate program.

Table 12 below provides a list of the funding codes and their corresponding program name.

Table 12: MCSS/MCYS Program Name and Project Code

Project Code	Program
158	Residential Placement and Advisory Committee
162	Child Abuse Program
164	Child & Family Intervention – Preparation for Independence
450	Child Treatment – Operating - Non-Residential
636	Standardized Intake and Assessments
651	Intensive Child & Family Services
658	Mobile Crisis
665	Children's Mental Health (0 to 6 years)
676	Access Mechanisms
77	Child & Family Intervention Operating Residential
78	Child & Family Intervention Operating Non-residential

Source: 2003/2004 MCSS/MCYS Service Detail and Transfer Payment Status

These services are provided by community organizations referred to as ‘transfer payment’ agencies – a term resulting from the fact that the Ministry transfers public funding to these organizations to operate these programs and services. Most of these transfer payment agencies are governed by boards of directors comprised of volunteers from the community. All of these organizations receive funding through a service contract with MCSS/MCYS in which they agree to provide specific services. In the Niagara community, there are five different organizations that receive funding to provide services in the 11 different categories of children’s programs noted. The agencies, the number of programs they provide and the funding received in 2003/04 are presented in Table 13 below.

Table 13: Agencies, Number of Programs and Funding

Organization	# of Programs	Annualized Funding 2003/04	% of Total Funding
Niagara Centre for Youth Care	3	\$2,584,131	45.3%
Centre de santé communautaire	1	\$105,000	1.8%
Niagara Child Development Centre	5	\$2,477,907	43.5%
Hotel Dieu Hospital Health Sciences Centre	1	\$60,489	1.1%
Contact Niagara	3	\$472,657	8.3%
Total	13	\$5,700,184	

Source: 2003/2004 MCSS/MCYS Service Detail and Transfer Payment Status

For information purposes, as of April 1, 2004 the Niagara Centre for Youth Care and the Niagara Child Development Centre were amalgamated to form a new single agency known as “Niagara Child and Youth Services” (NCYS). However, all data that was acquired during the period over which this community service plan was carried out was sourced to NCYS’ two parent organizations. For this reason, therefore, both agencies are cited throughout this report as the basis for presenting all financial and utilization data.

The key points illustrated by Table 13 include:

- In total, Niagara agencies received \$5,700,184 in annualized funding for the 2003/04 fiscal year.
- Three agencies provide more than one service.
- Two agencies - Niagara Centre for Youth Care and the Niagara Child Development Centre - received 89% of the total funding.

To help explain how this service system is structured, a service framework was developed, based on the work of the South West Region Children’s Mental Health Services Project. This framework, which describes how services are differentiated from one another and organized within the community, is provided in Appendix One. It

describes services along a continuum which comprises four levels: highly specialized services, residential services, core services and access services.

Highly Specialized Services include psychiatric support, acute care hospitalization and crisis treatment. These services address the most severe and complex needs of children and youth. They may be located in the community or regionally. Currently none of these services are being funded through MCSS/MCYS. These services, when required, are primarily funded through the Ministry of Health and Long-term Care.

Residential Services are provided to children in group care or residential settings where the child is receiving care and treatment outside of his/her own home. The intent is to provide these services as close to the child's home as possible.

Core Services refers to services such as assessment and clinical services, crisis treatment and home-or-school based services. These represent a broad range of service options, provided in the community.

Access Services provide children and their families with information about the system, referral to services and case resolution which involves processes for addressing the complex needs of children in difficult and challenging circumstances.

Table 14 presents an overview of the MCSS/MCYS children's service system within the context of the service framework described above. It divides the programs into the four levels of service and also identifies which agencies provide which programs/project codes, how much funding is provided in each program area and what percentage of the total amount of funding this represents.

Table 14: Level of Service by Program by Agency

Types of Programs Funded, Project Code and Funding Received	Name of Agencies that Provide the Program
Highly Specialized Services Psychiatric Support and Consultation, Acute Care Hospitalization, Crisis treatment No MCSS/MCYS funding to agencies to provide these services	
Residential Services Total MCSS/MCYS funding 2003/04 \$964,060 (16.9% of Total)	
Child and Family Operating Residential (Project Code 77) Funding: \$ 964,060 (in 03/04) 16.9% of total MCSS/MCYS funding	Niagara Centre for Youth Care

Types of Programs Funded, Project Code and Funding Received	Name of Agencies that Provide the Program
Core Services Total MCSS/MCYS funding 2003/04 \$4,266,467(74.8% of Total)	
Child and Family Intervention – Operating –Non Residential (Project Code 78) Funding: \$2,764,867 (in 03/04) 48.5% of total MCSS/MCYS Funding	Centre de santé communautaire Hotel Dieu Hospital NHS Niagara Centre for Youth Care Niagara Child Development Centre
Standardized Intake and Assessment Instruments (Project Code 636) Funding: 03/04 \$9,000 - 2%	Niagara Centre for Youth Care Niagara Child Development Centre Contact Niagara
Intensive Child and Family Services (Project Code 651) Funding: 03/04 \$449,090 - 7.9%	Niagara Child Development Centre
Mobile Crisis (Project Code 658) Funding: 03/04 \$443,510 - 7.8%	Niagara Child Development Centre
Children's Mental Health (Project Code 665) Funding: 03/04 \$600,000 - 10.5%	Niagara Child Development Centre
Access Services Total MCYS funding \$469,657 (8.2% of Total)	
Residential Placement Advisory Committee (Project Code 158) Funding: 03/04 \$ 53,628 - .9%	Contact Niagara
Access Mechanisms Children's (Project Code 676) Funding: 03/04 \$416,029 - 7.3%	Contact Niagara

Source: 2003/2004 MCSS/MCYS Service Detail and Transfer Payment Status Reports

The key points illustrated by Table 14 include:

- The majority of resources are allocated within the level of core services (\$4.266m or 74.8% of the total).
 - Approximately 89.3% (\$3.813m) of all annual resources within this level are dedicated to the home/school based cluster.
 - Crisis treatment receives 10.4% (\$0.443m).

- Residential/out of home services account for approximately 16.9% (\$0.964m) of total expenditures.
- Access services account for approximately 8.2% (\$0.469m) of total expenditures.

Table 15 below presents annual funding by program area and project code for 2002/03 and 2003/04. The number of individuals served in each of the program areas is also included, however, only for the 2002/03 fiscal year. Also indicated are how many agencies provide each program.

Table 15: Programs, Budget Allocations 2002/03 and 2003/04, #s of Individuals Served and # of Agencies Providing Service

Project Code	Program	# of Agencies Providing Program	Annual Budget 02/03	% of County Total	# of Individuals	% of Total Served	Annual 03/04	% of County Total
158	Residential Placement Advisory Committee	1	\$53,628	0.9%	15	0.3%	\$53,628	0.90%
636	Standard Intake and Assessment Instruments	3	\$6,000	0.1%		0.0%	\$9,000	0.20%
651	Intensive Child & Family Services	1	\$475,565	8.3%	149	2.5%	\$449,090	7.90%
658	Mobile Crisis	1	\$417,035	8.4%	1129	19.1%	\$443,510	7.80%
665	Children's Mental Health (0 - 6)	1	\$600,000	10.5%	260	4.4%	\$600,000	10.50%
676	Access Mechanism	1	\$416,029	7.3%	2186	36.9%	\$416,029	7.30%
77	Child & Family Intervention - Residential	1	\$964,060	16.9%	138	2.3%	\$964,060	16.90%
78	Child & Family Intervention - Non-Residential	4	\$2,764,867	48.5%	2040	34.5%	\$2,764,867	48.50%
	Total	13	\$5,697,184		5917	100.0%	\$5,700,184	

Source: 2002/03 and 2003/2004 MCSS/MCYS Service Detail and Transfer Payment Status Reports

The key points illustrated in Table 15 include:

- The total annual allocation for children's services in the Niagara region (2003/04) was \$5,700,184.

- Approximately:
 - 48.5% (\$2.764m) was directed towards services within the child and family intervention –non-residential program area.
 - 16.9% or \$0.964m was directed to child and family intervention – residential program area.
 - Children's mental health (0-6) received 10.5% or \$0.600m.
 - Intensive child and family services received 7.9% or \$0.449m
 - Mobile crisis received 7.8% or \$0.443m.
 - These five funding categories (of a total of 8 funding categories) accounted for approximately 91% of total expenditures.
- The allotments for each of the remaining funding categories range from 0.2% or \$9,000 (standardized intake & assessment instruments) to 7.3% or \$0.416m (children's access mechanism).
- From the perspective of the residential / non-residential ratio, \$0.964m or 16.9% of total funding was designated for residential services as compared to non-residential resources which constitute the balance of funding at \$4.736m or 83.1% of the total allocation.
- The total funding for the 02/03 fiscal year was \$5.697m while for 2003/04 it rose marginally to \$5.700m.
- 5,917 individuals received services over the 2002/03 fiscal year. It is important to note, however, that these statistics do not in fact record the total number of individuals served, but the number of instances where services are provided. This figure also includes the access statistics. Thus anyone going through the access and referral process (Contact Niagara) would be counted both at the access point and also again when they receive service at the agency.
- Residential services served 138 individuals (2.33% of total individuals served) with 16.9% of the total annual allocation.
- Non-residential services (child and family intervention) served 2,040 individuals (34.48%) and received 48.5% of the allocation.
- The access mechanism for children served 2,186 (36.9%) individuals with 7.3% of the allocation.
- Mobile crisis served 1,129 (19.0%) individuals with 8.4% of the total allocation.
- The remaining funding envelopes provided service to 424 (7.2%) of the individuals with 19.8% of the total allocation.

Table 16 below provides a secondary analysis of funding and individuals served by excluding the data from Contact Niagara. As noted above, individuals who proceed through the access process will be counted again at the point of receiving intervention services.

Table 16: Number of Individuals Served Excluding Access Services

Program	Annual Budget 02/03	% of County Total	Number of Individuals Served	% of county Total	Average Cost Per Client
Residential Placement Advisory Committee	\$53,628	0.90%	15	0.40%	\$3,575
Standard Intake and Assessment Instruments	\$6,000	0.10%			
Intensive Child& Family Services	\$475,565	8.30%	149	3.99%	\$3,192
Mobile Crisis	\$417,035	8.35%	1129	30.26%	\$369
Children's Mental Health (0 – 6)	\$600,000	10.50%	260	6.97%	\$2,308
Access Mechanism	\$416,029	7.30%			\$190
Child & Family Intervention – Residential	\$964,060	16.90%	138	3.70%	\$6,986
Child & Family Intervention – Non-residential	\$2,764,867	48.50%	2040	54.68%	\$1,355
Total	\$5,697,184		3731		

Source: 2002/03 and 2003/2004 MCSS/MCYS Service Detail and Transfer Payment Status Reports

The key points shown in this table are:

- When the 2,186 instances of access services are removed from the count the actual number of direct services being received is 3,731.
- Once the access numbers are excluded, 54% of the services are child and family intervention non-residential and 30% are mobile crisis services.
- The average cost per client within residential services is \$6,986, while for all other services combined, excluding 'access', it is \$1,201 per client.

For broad contextual purposes, Table 17 provides an overview of funding, individuals served and child population across the Hamilton – Niagara Region by county. Funding and individuals served are for the 2002/03 fiscal year.

Table 17: Individuals Served By County and Region

County	2002-2003 Annual Allocation	Percent of Regional Total	# of Individuals Served	Percentage of Regional Total	Child Population	Percentage of Regional Total
Brant	2,347,991	11.0%	2017	10.24%	30805	11.15%
Haldimand Norfolk	1,580,879	7.0%	1887	9.58%	27555	9.98%
Hamilton	11,694,674	54.8%	9869	50.12%	121280	43.91%

County	2002-2003 Annual Allocation	Percent of Regional Total	# of Individuals Served	Percentage of Regional Total	Child Population	Percentage of Regional Total
Niagara	5,697,184	26.7%	5917	30.05%	96535	34.95%
Region Total	21,320,728		19690		276175	

Source: 2002/03 and 2003/2004 MCSS/MCYS Service Detail and Transfer Payment Status Reports

The key points illustrated by Table 17 include:

- The total funding for the 2002/03 fiscal year for the Hamilton Niagara region was \$21.320 million.
- Hamilton received \$11.694 million or 54.8% of the total funding for the Hamilton Niagara Region.
- Niagara Region received \$5.697m or 26.7% of the total regional allocation.
- Hamilton served 50.1% of all children served across the H/N Region compared to Niagara which served 30.0% of all children served.
- From a child population perspective, Hamilton has 43.9% of the total child population across the Hamilton Niagara Region compared to Niagara at 34.9%.

SERVICE NEEDS

In order to understand and predict how much of a particular program or service may be required; it is helpful to look at how frequently one could expect a particular condition or problem to occur. In other words, it is important to measure the 'prevalence rate' of particular disorders. Based on the work of Charlotte Waddell and Cody Shepherd, *Prevalence of Mental Disorders in Children and Youth* (Mental Health Evaluation Department of Psychiatry, Faculty of Medicine at the University of British Columbia October 2002), given the total child population is 96,535 for the Niagara Region (0 – 18 Inclusive), one could expect in Niagara a prevalence rate of any mental health difficulty to be 15% or 14,480 children and youth. Table 18 provides the prevalence rate for various disorders together with the number of cases that could be expected in Niagara.

Table 18: Population and Prevalence

Prevalence of clinically significant child mental health problems in Niagara	Prevalence %	Number of children / youth in Niagara
Any anxiety disorder	6.5	6,275
Conduct disorder	3.3	3,186
Attention deficit/hyperactivity disorder	3.3	3,186

Prevalence of clinically significant child mental health problems in Niagara	Prevalence %	Number of children / youth in Niagara
Any depressive disorder	2.1	2,027
Substance abuse	0.8	772
Pervasive developmental disorder	0.3	290
Obsessive-compulsive disorder	0.2	193
Schizophrenia	0.1	97
Tourette's Disorder	0.1	97
Any eating disorder	0.1	97
Bipolar disorder	0.1	97
Any disorder	15	14,480
2001 Census – Niagara		
0-4	21235	
5-9	25790	
10-14	27885	
15-18 Inclusive	21625	
TOTAL	96535	

Source: Charlotte Waddell and Cody Shepherd, *Prevalence of Mental Disorders in Children and Youth*

UTILIZATION: SOURCES OF DATA

Two primary sources of data were used to develop an understanding of overall utilization – the ‘Agency Data Template – October 2003’ and ‘Webtracker’ which is the information system used by Contact Niagara for children’s and developmental services.

Agency Data Template

As part of the data collection process, agencies were asked to complete an agency data template for the fiscal year 2002/03. The data provided information about the different program areas and identified how many individuals were admitted to service by age grouping (under 6, 6- 12, 13 – 15, 16- 18), how many individuals received service by age grouping and how many individuals were on the wait list at September 30, 2003. The response rate from agencies was 100%.

Webtracker – Contact Niagara

In addition, information was collected from Contact Niagara’s Webtracker information system on intake and referral data for the period April 1, 2003 – March 31, 2004. In

order to better appreciate the data, a brief overview of the information system, along with definitions of the terminology used is necessary.

The overall system is divided into two major components – Request and Intake. Every call received by Contact Niagara is initially treated as a ‘request for service’. That request is immediately categorized into one of the following:

- *Information calls* - simply involve providing the caller with information and does not proceed to an intake
- *Consultations* – similar to information calls, these involve providing advice and options to assist the caller find the resources they need in the community related to a specific case that has been described to the Resource Coordinator; as with information calls, these do not proceed to an intake
- *Intake* - the call results in a full intake and referral(s)

The second major component of the system organizes all data around what is defined as the ‘intake record’. For information purposes, the intake document provided to agencies is a reflection of the majority of the information gathered at this stage by Contact Niagara. It is important to note that while a single ‘client record’ is created with each new individual, there may be more than one ‘intake record’ created. For information purposes, multiple intake records are required in instances where an individual requests additional referrals at a later point in time. When these requests are received, the most recent intake record is updated to ensure accuracy and relevance.

Finally, in keeping with Contact Niagara’s mandate as the point of entry for the two sectors of developmental and children’s services, consumer information is organized by “sector”. For information purposes, there are three: ‘children’s’, ‘developmental’ and ‘both’. The first two are self-explanatory however, it is important to note that the latter category was created to account for individuals who require and/or request services / supports from both sectors.

UTILIZATION ANALYSIS

Data provided through the Agency Data Template provides an overview of the number and ages of children receiving various kinds of services. This is shown from two perspectives in the following tables, first by looking at children who started services during the fiscal year April 2002 to March 2003 and secondly those who received services during that time period.

Table 19: Children Who Began Service by Age Cohort and Program

Program Area	0 to 6	6 to 12	13 to 15	16 to 17	Total
Child and Family Intervention – Non Residential	34	438	928	1041	2441
Child and Family Intervention-Residential	0	0	82	56	138
Children's Mental Health 0-6	260	0	0	0	260
Intensive Child and Family Services	12	131	4	2	149
Mobile Crisis	6	180	426	517	1129
Total	312	749	1440	1616	4117
Percent of Total	7.6%	18.2%	35.0%	39.3%	100.0%

Source: Agency Data Template October 2003

Table 20: Children Who Received Services by Age and Program

Program Area	0-6	6-12	13- 15	16-17	18 +	Total
Child and Family Intervention Non- residential	34	438	928	1006	83	2489
Child and Family Intervention Residential	0	0	82	56	0	138
Children's Mental Health 0-6	0	0	0	0	0	0
Intensive Child and Family Services	12	131	4	2	0	149
Mobile Crisis	6	180	426	517	44	1173
Total	52	749	1440	1581	127	3949
Percent of Total	1.3%	19.0%	36.5%	40.0%	3.2%	100.0%

Source: Agency Data Template October 2003

The key points shown in Tables 19 and 20 are:

- A total of 4,117 individuals entered service and 3,949 received service.
- The largest group of individuals by age cohort to begin service were youth 16-17 at 1,616 individuals (39.3%) followed by youth 13-15 years of age at 1,440 (35%). Children 6-12 years of age represented 18% (749) of total admissions with children under six representing 7.6% (312) of admissions.
- Youth 16-17 also represented a greater proportion of total individuals who received service at 1,581 (40%) again followed by 13-15 year olds at 1,440 or 36.5% of all individuals who received service during the 2002/03 fiscal year.

- The overall pattern noted above is applicable within each of the funding categories. For example, within the non-residential funding line, 1,006 (40% for that funding category) 16-17 year olds received followed by 13-15 year olds at 928 (37.2%).

Table 21 illustrates the number of requests for services received by Contact Niagara between April 1, 2003 and March 31, 2004. It indicates the numbers of requests for children mental health services as well as those that requested both children's mental health and developmental services.

Table 21: New Requests by Type

Request Type	TOTAL		CMH Sector		Both Sectors	
Intake	2393	58.1%	1520	61.4%	147	83.5%
Information	878	21.3%	401	16.4%	16	9.0%
Consultation	846	20.5%	552	22.3%	13	7.3%
TOTAL	4117		2473		176	

Source: WEBTRACKER Contact Niagara for Children's and Developmental Services

The key points shown in this table are:

- There were a total of 4,117 requests for service of which 58.1 % resulted in an intake.
- In the children's mental health sector there were 2,473 requests for services of which 61.4% resulted in intakes.
- There were 176 requests for both children's mental health and developmental services and 83.5% of these resulted in an intake.

Table 22 shows referrals by who advised, recommended or directed the person to seek help. Table 23 shows who actually made the direct contact with Contact Niagara.

Table 22: Referral by Who Directed

Directed By	TOTAL		CMH Sector		Both Sector	
Self	1492	45.2%	815	39.1%	23	51.1%
School	419	12.7%	327	15.6%	5	11.1%
FACS (CAS)	351	10.6%	291	13.9%	0	0
Other Professionals	348	10.5%	229	10.9%	6	13.3%
Physician	282	8.5%	216	10.3%	4	8.8%
Family	179	5.4%	104	4.9%	5	11.1%
All Other	227	6.8%	101	4.8%	2	4.4%
TOTAL	3297		2083		45	

Source: WEBTRACKER Contact Niagara for Children's and Developmental Services

Table 23: Top Six Requesters for Service Who Made the Contact

Requestor	TOTAL		CMH Sector		Both Sector	
	Count	%	Count	%	Count	%
Mother/Father	1624	57.8%	1294	69.0%	16	42.1%
Other Prof.	301	10.7%	84	4.4%	7	18.4%
FACS (CAS)	253	9.0%	182	9.7%	3	7.8%
Self	154	5.4%	51	2.7%	2	5.2%
School	120	4.2%	74	3.9%	1	2.6%
Physician	96	3.4%	49	2.6%	4	10.5%
All Other	261	9.2%	139	7.4%	5	13.1%
TOTAL	2809		1873		38	

Source: WEBTRACKER Contact Niagara for Children's and Developmental Services

The key points illustrated by Tables 22 and 23 include:

- More than 45% of the referrals are self referrals.
- In over 57% of the cases, the actual contact is made by the mother or father.
- Schools, Family and Children's Services (FACS), other professionals and physicians are the most frequent other sources of referrals.

Contact Niagara data also tracks referrals by service need and programs. Table 24 shows the total referrals by services, while Table 25 shows referrals by programs.

Table 24: Total Referrals by Service Need & Sector

Service Need	TOTAL	% TOT	CMH		BOTH	
			Number	%Total	Number	% Total
Counselling	1169	64.6%	1123	69.9%	46	22.6%
Assessment / Consultation	158	8.7%	112	6.9%	46	22.6%
Behaviour Intervention	144	7.9%	126	7.8%	18	8.8%
Residential Treatment	70	3.8%	62	3.8%	8	3.9%
Day Treatment	67	3.7%	64	3.9%	3	1.4%
Residential Support	46	2.5%	38	2.3%	8	3.9%
Service Coordination (e.g. APSW)	40	2.2%	17	1.0%	23	11.3%
Intensive Child	40	2.2%	35	2.1%	5	2.4%
Respite	38	2.1%	12	0.07%	26	12.8%
All Other	37	2.0%	14	0.08%	23	11.3%
TOTAL REFERRALS	1809		1606		203	
TOTAL UNIQUE INDIVIDUALS	1489		1396		93	

Source: WEBTRACKER Contact Niagara for Children's and Developmental Services

The key points shown in this table are:

- The number of total referrals was 1,809; these were made on behalf of 1,489 unique individuals.
- Over 64% of the referrals were for counselling.

Table 25: Total Referrals by Program & Sector

Program	TOTAL	% TOT	CMH		BOTH	
			Number	% Total	Number	% Total
Family Intervention	621	34.3%	607	37.8%	14	6.9%
Child and Family Counselling	266	14.7%	251	15.6%	15	7.4%
Single Session	122	6.7%	121	7.5%	1	0.5%
EASI	110	6.0%	103	6.4%	7	3.4%
Day Treatment	76	4.2%	73	4.5%	3	1.5%
STOP	63	3.4%	61	3.8%	2	1.0%
Family Support Alternative	62	3.4%	59	3.7%	3	1.5%
Residential Treatment	62	3.4%	58	3.6%	4	2.0%
NPRS	56	3.0%	54	3.4%	2	1.0%
Residential	48	2.6%	43	2.7%	5	2.5%
CDAS	46	2.5%	14	0.87%	32	15.8%
Regional Respite	37	2.0%	12	0.75%	25	12.3%
Intensive Child & Family	32	1.7%	23	1.4%	9	4.4%
Preschool	29	1.6%	28	1.7%	1	0.5%
Wraparound	27	1.4%	20	1.2%	7	3.4%
Family Support Services	27	1.4%	8	0.50%	19	9.4%
Assessment	25	1.3%	23	1.4%	2	1.0%
Specialized Funding	22	1.2%	19	1.2%	3	1.5%
Mental Health Residential	11	0.6%	7	0.44%	4	2.0%
All Other	67	3.7%	22	1.4%	45	22.2%
TOTAL REFERRALS	1809		1606		203	
TOTAL UNIQUE INDIVIDUALS	1489		1396		93	

Source: WEBTRACKER Contact Niagara for Children's and Developmental Services

The key points shown in this table are:

- More than 1/3 of the referrals were for the family intervention program.
- 14.7% were for child and family counselling.

The data also illustrates the community of origin of those individuals seeking service.

Table 26: Referrals by Places of Residence

Place of Residence	Percentage of Referrals	Percentage of Regional Population
St. Catharines	37.0%	33.0%
Niagara Falls	14.0%	19.0%
Welland	14.5%	17.0%
Fort Erie	7.7%	7.0%
Lincoln	2.5%	5.0%
Grimsby	2.0%	5.0%
Thorold	4.0%	4.0%
Port Colborne	4.6%	4.0%
Pelham	2.5%	3.0%
Niagara-on-the-Lake	2.0%	3.0%
West Lincoln	2.5%	3.0%
Wainfleet	1.0%	2.0%

Source: WEBTRACKER Contact Niagara for Children's and Developmental Services

The key point shown in this table is:

- The number of referrals by jurisdiction as compared to the proportionate population of that jurisdiction follows closely the distribution of population across the Niagara Region.

The number of people waiting for services by program is provided in the two tables to follow. The first (Table 27) is based on information Contact Niagara receives from agencies once a referral was made. Table 27 is an analysis of the waitlist as it stood on March 31/04. The second table (Table 28) is based on data provided by the agencies through the Agency Data Template. Table 28 is an analysis of the waitlist as it stood on September 30/03.

Table 27: Waitlist as of March 31, 2004

Program	TOTAL	% TOT	CMH		BOTH	
			Number	% Total	Number	% Total
Child & Family Counselling	119	45.8	111	47.2%	8	32.0%
Assessment	21	8.1%	20	8.5%	1	4.0%
EASI	21	8.1%	20	8.5%	1	4.0%
Family Support Alternative	19	7.3%	19	8.1%	0	0.0%
STOP	18	6.9%	18	7.7%	0	0.0%
Day Treatment	14	5.4%	13	5.5%	1	4.0%
Mental Health Residential	14	5.4%	12	5.1%	2	8.0%
NPRS	11	4.2%	11	4.7%	0	0.0%
Behaviour Supports, Children	5	1.9%	2	0.9%	3	12.0%

Program	TOTAL	% TOT	CMH		BOTH	
			Number	% Total	Number	% Total
Intensive Child & Family	4	1.5%	4	1.7%	0	0.0%
Autism Consultation	4	1.5%	1	0.4%	3	12.0%
All Other	10	3.8%	4	1.7%	6	24.0%
TOTAL REFERRALS WAITLISTED	260		235		25	
TOTAL UNIQUE INDIVIDUALS	250		229		21	

Source: WEBTRACKER Contact Niagara for Children's and Developmental Services

The key point shown in this table is:

- Over 45% of the people on wait list are waiting for child and family counselling

Table 28 below shows which specific program and agencies children were waiting for as of September 30 2003.

Table 28: Individuals Waiting for Service

Category	Agency	Children on Waiting List as of 09/30/03
Non-residential	Niagara Centre for Youth Care	38
	Niagara Child Development Centre	172
Total		210
Residential	Niagara Centre for Youth Care	0
Total		0
	Total	210

Source: Agency Data Template October 2003

The key point shown in this table is:

- As at September 30, 2003, 210 individuals were waiting for non-residential services (132 NCDC, 38 NCYC) while there were no individuals waiting for residential services.

BRIEF CHILD AND FAMILY PHONE INTERVIEW DATA

Overview

The Brief Child and Family Phone Interview (BCFPI) is a standardized or structured interview administered, primarily by telephone, with the parent/caregiver of a child aged 3 to 17 years who is requesting children's mental health services from an MCSS/MCYS

funded service provider. An adolescent self-report interview and a teacher interview are also available.

The BCFPI is designed to elicit and report on the strengths and concerns regarding a child's behavioural and emotional adjustment and the child and family's functioning. It also provides descriptive information regarding basic caregiver demographics, protective factors, risk factors, the child and family's readiness for service, and possible barriers to service utilization. It is designed to report this information on both an individual case level and an aggregate level.

The tool is used to assist individuals, families and providers in determining children's mental health needs and appropriate service responses. It is important to note that the BCFPI is not a comprehensive assessment instrument, rather it is designed to provide a screen for common referral concerns across a variety of mental health subscales, composite scales, and child and family functioning scales. The administration of the BCFPI is voluntary; however, most individuals and families are quite willing to provide the requested information. The table below presents the percentages of parents that completed the BCFPI form for referrals completed for the Hamilton Niagara Region from January 1, 2003 to September 30, 2003. Contact Niagara conducted 864 interviews and 758 (88%) of the parents filled out the parent form.

Table 29: Referrals and % of BCFPI Parent Forms for Each Area: January 2003 to September 2003

Community	Referrals	# of Parent Forms	% of Parent Forms
Brant	158	90	57%
Haldimand and Norfolk	119	97	82%
Niagara	864	758	88%
Hamilton	946	739	78%
Total	2087	1684	76%

Source: BCFPI data January 1 2003 - September 30 2003

Administration

For the Niagara community, the BCFPI is administered by trained Resource Coordinators employed by Contact Niagara. The interview typically takes place early in the intake stage when a determination has been made that a referral to a children's mental health service will likely take place.

The Parent Form of the BCFPI is administered to the parent/legal guardian/caregiver of a child, aged 3 - 17 years, with the following conditions:

- The parent/legal guardian of the child 3-17 years of age consents to the administration of the BCFPI.
- The parent/caregiver has provided continuous care for the child for a period exceeding three months prior to referral.
- When the child's caregiver of the preceding three months is not the legal guardian, verbal consent from the legal guardian is obtained to complete the BCFPI with the current caregiver.
- The youth 16-17 years of age consents to the administration of the BCFPI with their parent/caregiver.

The BCFPI is not administered when one of the following conditions apply:

- The child/youth is currently receiving treatment.
- The child/youth is currently in the process of ending treatment.
- The child/youth is being referred for Single Session Therapy or Crisis Services only.
- A BCFPI has been completed for the child/youth within the six months preceding the current referral, unless there has been a significant change in the presenting problem and/or nature of the request.

The Self Report Form of the BCFPI is administered to the child/youth between the ages of 12 - 17 years when the youth has requested children's mental health services without the knowledge, or consent of their legal guardian, and/or when the circumstances of the referral indicate that the youth is in the best position to provide the required information. The youth 16-17 years of age who refuses to consent to the administration of the Parent Form with their parent/legal guardian/caregiver are offered the opportunity to complete the Self-Report Form.

BCFPI Data

The following information provides an aggregated summary of BCFPI data covering the period January 1, 2003 to September 30, 2003. In total, 2087 referrals to children's mental health services across the Hamilton-Niagara Region are summarized in the presented data. All of the following material is based on the information provided by parents and caregivers through the use of the BCFPI Parent Form.

For purposes of this report, information is provided on the provincial, regional and local level. It is important for the reader to note that the BCFPI is used differently from area to area. Within the Hamilton/Niagara Region, a central point of contact is used for accessing children mental health services (Chedoke Child and Family Centre being the

exception) whereas this is not the case in other areas of the province. Within the Hamilton/Niagara region, Contact Hamilton and Contact Niagara are using the BCFPI for referrals for children ages 3-6 whereas this is not the case in the Brant and Haldimand-Norfolk communities. These differences will account for some of the data differences noted in the following tables.

The BCFPI measures a number of problem areas where a child may be in need of help. A score above 70 in these problem areas indicates that the child has a high enough risk that he/she is likely in need of mental health services. A score above 70 in any of the defined areas would only be expected in 2% of the general population. The following table indicates the number of problem areas in which children in each of the communities in the Hamilton Niagara Region scored over 70.

Table 30: Number of Scores over 70 by Community

Number of Scores over 70 By Community	Community			
	Brant	Hald. Nor	Ham.	Niagara
zero	14%	21%	15%	7%
one	12%	10%	12%	10%
two	20%	9%	13%	13%
three	16%	13%	18%	15%
four	13%	16%	12%	18%
five	13%	13%	14%	16%
six	9%	11%	10%	13%
seven	2%	5%	4%	7%
eight	0%	0%	1%	2%

Source: BCFPI data January 1, 2003 - September 30, 2003

The key points shown in this table are:

- 92 percent of the interviews conducted in Niagara had scores above 70 in one or more problem areas.
- 75 percent of those interviewed were identified as having problems in between two and six of the problem areas measured by the BCFPI.
- 7 percent of BCFPI interviews conducted in Niagara did not have scores above 70 in any of the problem areas measured by the BCFPI. This compares to 21 percent in Haldimand and Norfolk and 15 percent to Hamilton.

Further analysis of the BCFPI data showed that 38 percent of the interviews conducted in Niagara involved children from single parent families and 30 percent of the households had incomes below \$20,000 a year. Twenty one percent of interviews involved single parent families with incomes below \$20,000.

Table 31: Hamilton Niagara Region BCFPI by Family Status

	Single Parent	Family Income <\$20k	Single/low income	Family Income >60k
Brant	52%	48%	41%	12%
Haldimand Norfolk	28%	36%	20%	21%
Hamilton	47%	33%	26%	22%
Niagara	38%	30%	21%	21%
Total	40%	31%	23%	24%

Source: BCFPI data January 1, 2003 - September 30, 2003

In Niagara, eight domain areas of the BCFPI are used as a Most in Need Tool to assess priority regarding mental health referrals. The table below presents these eight problem areas along with the percentages of children that scored over 70 in the Niagara community.

Table 32: BCFPI Interviews Exceeding Clinical Score in Niagara

Problem Area	%
Cooperativeness	60
Regulation of Attention, Impulsivity and Activity	48
Ability to Manage Mood	45
Conduct	49
Ability to Manage Anxiety	22
Ability to Function Separately from Parent	21
Global Child Functioning	56
Family Adjustment	71

Source: BCFPI data January 1, 2003 - September 30, 2003

The key points shown in this table are:

- Family adjustment issues were present in 71% of the interviews.
- Problems with cooperativeness (60%) and regulation of attention, impulsivity and activity (48%) were the most prevalent externalizing problems.
- The ability to manage anxiety and mood were problem areas for 22% and 45% of the children respectively.

SUMMARY OF CASE RESOLUTION MEETINGS

Contact agencies are responsible for facilitating a community process known as the Resolution Mechanism. The mechanism is in place to respond to:

- Situations that are urgent and/or sufficiently complex that cannot be met within the usual mandates and services of agencies.
- Situations where all other steps to achieve resolution have been exhausted, or there is no expected benefit from other processes.
- Situations that require immediate and direct access to the resolution process, due to the nature and urgency of the situation.
- Situations where earlier processes have not identified an appropriate response due to barriers.

Given the above, a review of resolution statistics may highlight pressures and/or gaps within the community's service system. Data from Contact Niagara for the past three fiscal years is presented below:

Table 33: Case Resolution Meeting Summary

Category	Fiscal year	Total Meetings	Total People	Needs
Children's Mental Health	2003/2004	5	2	<ul style="list-style-type: none"> • Residential and specialized residential treatment
	2002/2003	9	3	
	2001/2002	0	0	
Children with a Dual Diagnosis	2003/2004	0	0	<ul style="list-style-type: none"> • No cases
	2002/2003	0	0	
	2001/2002	0	0	
Children with a Developmental Disability	2003/2004	3	2	<ul style="list-style-type: none"> • Residential treatment
	2002/2003	4	1	
	2001/2002	0	0	
Adults with a Developmental Disability	2003/2004	6	5	<ul style="list-style-type: none"> • Residential, intensive residential and specialized residential
	2002/2003	9	8	
	2001/2002	0	0	
Totals		36	18*	

*three individuals were counted in both fiscal years because meetings spanned both years

Source: Contact Niagara for Children's and Developmental Services

The key points shown in this table are:

- The greatest need exhibited in the case resolutions meetings was the need for residential and specialized residential treatment.

KEY QUESTIONS

The facts and figures presented in this section serve to answer two of the key questions posed at the beginning of the planning process:

First, what is the nature and magnitude of the demand for MCSS/MCYS-funded services and supports within this jurisdiction? The review of the service system revealed the following:

- Based on the Agency Data Template, between April 1, 2002, and March 31, 2003, 4117 individuals entered services and 3,849 received services, with the largest age group beginning services being youths for 16 -17 (39.3%) followed by youths 13- 15 years old (35%).
- Based on WEBTRACKER data, for the fiscal year beginning April 1/03 and ending March 31/04 Contact Niagara initiated 1,809 referrals on behalf of 1,489 unique individuals. More than 64% of the referrals were for counselling services and more than 34% of them were for family intervention programs.
- Based on information drawn from the Brief Child and Family Phone Interviews, 75 % of those interviewed had problems in 2 to 6 problem areas, while only 7% did not have any scores above 70. Family adjustment issues were present in 71% of the interviews while problems with cooperativeness were present in 60% of the interviews. In addition, about 30% of the families come from households with an annual income of less than \$20,000 and 21% come from low income single parent families.
- The waiting list as of March 31, 2004, revealed a total of 260 referrals waitlisted, representing 250 unique individuals, 45.8% of them waiting for child and family counselling.

Second, what resources are available to respond to that demand and how are they currently being used? The review of the service system revealed the following:

- Niagara's children's services system received approximately \$5.7 million in annual funding in 2003/04 from MCSS/MCYS.
- Within Niagara, 5 transfer payment agencies received funding for children's services.

- The majority of funding was allocated between 3 project codes:
 - Child and Family Intervention Operating (Non-residential) - 48.5%
 - Child and Family Intervention Operating (Residential) -16.9%
 - Children's Mental Health 0-6 Initiative -10.5%
- Using a framework of specialized, out-of-home/residential, core and access services, resources were allocated accordingly:
 - Specialized (0%)
 - Residential Out-of-Home (16.9%)
 - Core services (74.8%)
 - Access (7.3%)
- Two agencies received 88.8% of the children's resources. The largest percentage of funding was allocated to the Niagara Centre for Youth Care (45.3%) and Niagara Child Development Centre (43.5%).
- Collectively, the system served 5,917 individuals in 2002/03 (Note: these are not unique individuals).
- If the access statistics are excluded, the system served 3,731 individuals in 2002/03. An analysis by project code reflects the percentage of individuals served:
 - Child and Family Intervention Operating (Non residential) - 54.6%
 - Mobile Crisis - 30.26%
- While residential services received 16.9% of the 2002/03 annual funding, they served only 2.3 % or 3.7% (adjusted) of total individuals served.

In order to answer the other key questions about the service system posed at the beginning of this process, it is necessary to look beyond these facts and figures to consider the experiences of people involved with the system. The next section of this report explores these areas.

Part Four:

Perceptions of the Children's Service System

OVERVIEW

The first step in creating this community service plan involved collecting information on patterns: describing the community and the general population, the current service system and the context in which it operates, how resources are allocated and what measurable results are achieved. The next step involved finding out about people's experience with the service system. This entailed gathering information about people's perceptions, observations and opinions. While the information gathered in the first step was mostly "hard" or quantitative data, the second step involved "soft" qualitative data that is necessarily more difficult to capture and evaluate. This qualitative information is nevertheless just as important as the hard data, since it provides a basis for assessing what is working and what is not working, whether people are finding what they are looking for and how well their needs and expectations are being met. This is the information that can be used to make sure that the planning process puts people first and that it draws upon the knowledge, experience and expertise of those who use the service system, as well as the service providers and other members of the community.

Several methods were used to capture the experience of users, providers and other stakeholders in the system. Telephone surveys as well as printed questionnaires were supplemented by focus groups and telephone interviews in order to ensure not only that a broad and representative range of views were elicited, but also that the responses were interpreted correctly in an unbiased manner.

CONSUMER PERSPECTIVES

Performance Measurement Survey

The first tool for finding out about the experiences of people using the service system was the Performance Measurement Survey. This is a province-wide tool designed to receive and record feedback from consumers on access mechanisms. This written survey is distributed only to Contact Niagara consumers who are proceeding through the access process for the first time. Consumers are asked to respond to a series of questions (13 altogether) that evaluate access services from three perspectives: timeliness of response, ease of access and responsiveness. Each response is scored on a numerical scale (in most cases from 1 to 3, with 1 being the most negative and 3 the most positive) and these scores are then tallied to provide a total score in each of the three categories. All of the completed questionnaires can therefore be analyzed to provide an average of clients' performance ratings for the access service as a whole, as well as each component of it. It should be noted, however, that, of all the surveys distributed, typically fewer than half and sometimes less than a third are completed and returned. There is therefore no way of determining from the survey results whether or not these assessments reflect the opinions of all who use the service.

Contact Niagara distributed a total of 252 surveys to families using children's services in 2002/03 and received 137 responses. The average scores were: 4.6 out of a possible 5 for timely response, 9.1 out of 10 for ease of access and 19.5 out of a possible 22 for responsiveness.

Telephone Survey

The data provided from the Performance Measurement Survey relates exclusively to the access mechanisms. For the purposes of the community service plan, it was determined that information pertaining to the children's services system as a whole needed to be solicited from a representative cross-section of consumers and people waiting for service. A telephone survey was chosen as an effective method for polling users on their experiences and perceptions.

Methodology

A questionnaire was designed and a random sample of 50 people selected from the children's services clients in Contact Niagara's database. These included: clients presently receiving services; clients who had completed or discontinued services; and clients who were on lists waiting for services. Telephone interviews were usually conducted with a parent, guardian or family member, since they were considered to be in a better position (than the client actually receiving the services) to answer many of the questions. The questions focused on experiences accessing services; strengths and weaknesses of the services; perceived gaps and barriers; and, suggestions for improving both the access process and overall services.

Generally speaking, a sample size of 50 cases has a sampling error (accuracy) of plus or minus 14 percentage points, 19 out of 20 times. While this level of accuracy could be improved upon, the survey was still able to generate useful information in terms of probing the views and experiences of the clients of a single service sector in this community. Confidence in the reliability of the information was also enhanced by a comparison of the random sample of people surveyed with a partial list of clients from Contact Niagara's database. The survey sample proved to be highly representative of the database, since it had the same proportion of female to male clients and, in the case of the developmental services survey which followed the same methodology, the same proportion of adult to children or youth.

Experience with access process

The survey began by asking people who first suggested that they get help. Most of the families reported that a parent, guardian, other relative or a friend had originally suggested getting help (52 percent, which represents 26 people altogether), while most of the others were urged to get help by schools (16 percent or 8 people) or doctors (also 16 percent).

When asked whether the supports or services that were recommended for them were in fact appropriate, 85 percent (41 people) indicated that they were, including 56 percent (27 people) who felt that they were *very* appropriate. On the other hand, 14 percent (7 people) believed that the recommended services were not appropriate (including two who felt that the services were *not at all* appropriate.)

All families in the survey were asked how satisfied they were with the overall process they went through to get connected to the supports or services that were needed. Seventy-nine percent (37 people) said they were *satisfied*, including 47 percent (22 people) who said they were *very satisfied*.

All respondents were asked why they felt the way they did regarding their level of satisfaction. After the reasons behind their feelings about the overall access process were reviewed, three main themes seemed to emerge: the timeliness of the process; the fact that the system was responsive to their needs; and competent and caring personnel involved in the access process.

The most common suggestion for improving the process was the need to include or expand outreach programs to make information more widely available to the community, to schools and to the doctors. Other suggestions included increasing resources and services; improving communication and follow-up with the families; and improving the timeliness of the access process.

How comprehensive were the services?

Two approaches were taken to measure the perceptions of the comprehensiveness of services offered in the system. First, the respondents were asked if all of their needed

supports and services were in fact available; and secondly, which services (if any) were not available.

Most of the families agreed that all of the supports and services were available (68 percent or 32 people), but a substantial minority disagreed (32 percent or 15 people) – including 13 percent (6 people) who disagreed *strongly*.

All respondents in the survey who disagreed that all of the services were available were probed further and asked which types of supports or services they thought were not available. The most frequently mentioned unmet need among families tended to centre on counselling services in general as well as psychiatric services. Other respondents mentioned a lack of services for very specific needs such as attention deficit hyperactivity disorder.

Barriers to receiving services

All families who were presently receiving services or who had received services recommended by Contact Niagara in the past (36 people altogether) were asked about possible barriers and obstacles that might have interfered with them getting help or taking advantage of services. The most frequently mentioned obstacle that interfered with getting services was the geographic location of the services (mentioned by 39% or 14 people) and transportation (36% or 13 people). The next most often mentioned barrier was having to take time off school or work (mentioned by 22% or 8 people). Other obstacles causing problems for getting services were the financial costs or out-of-pocket expenses (14 % or 5 people) and the hours that the supports or services were available (11% or 4 people).

In some cases, families reported that an obstacle or barrier was so great that it prevented or stopped the family from receiving the supports or services that were needed. Difficulties with transportation had this impact on 14 percent (5 people) and the geographic location of the services affected 11 percent (4 people) in the same way.

Experiences while waiting for services

Among the families interviewed, 12 percent (6) reported that they were waiting for services to start. Four of these families were waiting for only one service, while two families were waiting for three services. Most of the six families who were waiting for services felt that waiting was a problem – one said it was *somewhat* of a problem and four said it was a *large* problem.

Of the six families who were waiting for services, two said that the situation that the family tried to get help for had improved while waiting, two reported that it had remained the same and two indicated that the situation had gotten worse while waiting for services to start.

Experiences with services

Seventy-two percent of the respondents (36 people) said that they had some past or present experiences with children's services. They reported having received, over the past three years, an average of 1.9 services and 16 of the families said more than one service provider had served them.

Among those families who have had experiences with more than one agency or service provider, 86 percent (13 families) were satisfied with the way those services seemed to work together, including 53 percent (8 people) who said they were *very* satisfied. On the other hand, two families said they were somewhat dissatisfied with the coordination of these services.

All families that had past or present experiences with services were asked what they considered to be the most important strengths of those services or what they had particularly liked about them. The most frequently mentioned strengths were competent and caring staff and services that are responsive to the family's needs. Other strengths that were mentioned included the communication with the family and the fact that the service providers came to the home or to the school.

These families were also asked what they considered to be the most important weaknesses of the services they had been involved with or what they particularly did not like about them. The most frequently mentioned theme centred on specific or unique issues that related to the delivery of the services, e.g., difficulties with staff, communication. Other weaknesses that were mentioned included age restrictions or other limits or caps on service, inconveniences surrounding the hours that the services were available and the time they had to wait for the services.

The most common improvement that families suggested was to increase services and resources. The next most often mentioned suggestion was to remove or reduce restrictions related to age considerations, hours of service or caps on services. Another suggestion was to expand outreach to the community.

Impact of the services

All families in the survey who were either presently receiving services or who had received services recommended by Contact Niagara in the past were asked how they had been affected by the supports or the services that they had received. Families were asked if, as a result of the services they had received, the situation that they tried to get help for had improved, remained the same, or had gotten worse. More than three quarters of the families reported that the situation had improved (80%, 28 people) and 20 percent (7) of the families felt that the situation had remained the same. No family sensed that things had gotten worse.

Focus Group

The telephone survey was followed by a focus group session sponsored by Contact Niagara. Invitation letters were sent to a random selection of children's services clients in Contact Niagara's client database. The session was attended by five family members. The purpose of the session was to provide an update on the community service planning process in Niagara and solicit participant views and suggestions about the children's services system in the Region of Niagara.

Focus group participants identified similar strengths to those mentioned by questionnaire respondents, expressing satisfaction with the agencies, staff, and referrals received. They further identified centralized access and the children's mental health system generally as strengths.

The main weaknesses identified by focus group participants were: wait lists; difficulties in using services involving different ministries; lack of services (e.g., supports for transitional periods, in-home respite, crisis services); and resource shortages (e.g., psychiatrists, psychiatric nurses).

Participants were asked to suggest ideas for improving the children's services system in Niagara. They suggested improved levels of services (e.g., psychiatric, residential, counselling, in-home support, respite, prevention, transitional-aged supports, support groups), integration of services across ministries, public and school education programs, increased materials and resources, and addressing transportation issues.

SERVICE PROVIDER PERSPECTIVES

Survey Results

In order to obtain input from service providers a detailed six-page survey was designed and distributed to a selected sample of community groups and organizations, providers of MCSS/MCYS Children's Services and providers of related services. Three surveys were sent to the Executive Director of each respondent agency, with a request that he/she complete one and distribute one to a member of the Board of Directors and one to a manager/staff member.

Topics covered by the survey included:

- A system-level "SWOT" – strengths, weaknesses, opportunities, threats
- Perceived gaps or duplications in services and supports
- Views of overall system effectiveness
- Identified obstacles or barriers to service
- External Factors

- Identified external trends, events, issues and professional practices
- Suggestions for improving the current system and future priorities

Twenty-eight surveys representing 25 agencies were received from respondents in the children's services sector.

SWOT analysis

The key strengths of the children's services system identified by respondents were: knowledgeable and dedicated staff, collaborative service delivery, and the quality of existing services and programs, such as crisis services and day treatment.

The main weaknesses identified by respondents were: insufficient resources in terms of staff, financial resources, and system capacity; wait list issues; staff attitudes/practices; transportation/accessibility issues; and service gaps.

Respondents identified several areas of opportunity for the service system to improve upon: partnerships/collaboration; infrastructure (e.g., development of Niagara-based mental health beds); policy and funding implications of the recent change in government; use of best practices; and the expansion of services to meet needs.

The most frequently mentioned threats related to insufficient resources in terms of funding, staffing, and system capacity. Respondents also perceived service delivery issues as a threat, including lack of interagency collaboration and bureaucracy. Comments relating to the political environment were also noted.

Gaps

Respondents were asked to identify 3 of 11 possible services where there was a service gap as defined as a pressure between demand and supply. The main system gaps identified were in psychiatric services, residential, and assessment and diagnostic services. Furthermore, respondents were asked whether there were any necessary services or supports that presently do not exist in Niagara. Twenty-three of the twenty-four individuals who responded felt that services were not available, including: residential services; mental health/psychiatric services (inpatient and outpatient); community support services; and prevention programs. Respondents could not identify any areas of duplication of children's mental health services in Niagara, with the exception of the intake function mentioned by a few respondents.

Effectiveness of the system

In answering a series of questions about the overall effectiveness of the system of children's mental health services, respondents were asked to reply "excellent," "good," "fair" or "poor." These questions elicited 7 responses in the "excellent" category, 80 in the "good" category, 84 in the "fair" category and 32 in the "poor" category. The highest ratings related to collaboration and having a positive impact on clients. The lowest ratings

were in ensuring individuals received services in a timely fashion. Respondents referred to long waiting lists, inadequate resource levels, service gaps, service coordination issues, and transportation/accessibility problems as reasons for their low ratings.

Barriers

Respondents were asked to review a list of potential obstacles and barriers and indicate to what extent each posed a problem in Niagara. Transportation was seen to be the greatest barrier to individuals accessing children's mental health services, followed closely by the related issue of geographic location of services. Financial costs and having to take time off work or school were also identified as significant barriers. Respondents were also asked to identify any other obstacles and barriers that interfere with individuals and families receiving service, and the main issues raised were: insufficient system capacity with respect to funding, staff, and services; financial barriers; lack of awareness/insight; and social stigma.

External Factors

The most significant external factors seen as impacting on the system were the growing complexity of individual needs, increasing operating costs, recruitment and retention of qualified staff and the availability of community supports such as child care, training, housing and recreation.

Trends, Events, Issues, and Professional Practices

Several themes emerged from the comments about trends, events, issues, and professional practices that should be considered in community services planning. Respondents expressed that children's mental health problems within Niagara are increasing in both frequency and severity, and that only those individuals/families deemed most in need receive service. Other comments related to insufficient funding, service delivery and coordination issues, and service gaps.

Improvements and priorities

The most frequently mentioned suggestions for improvement of the system related to increasing services, increasing resources and improving collaboration among agencies. Respondents indicated that psychiatric services (inpatient and outpatient) should be given the top priority for future enhancement, followed by residential services, assessment/diagnostic services, and counselling.

Focus Group

The survey was followed by a focus group session sponsored by Contact Niagara. Invitation letters were sent to a selected sample of community groups and organizations, providers of MCSS/MCYS Children's Services and providers of related services. The session was attended by representatives from 13 different agencies and organizations in the Niagara Region. The purpose of the session was to provide an update on the

community service planning process in Niagara and solicit participant input to the emerging research findings.

SWOT analysis

Participants reviewed the SWOT analysis from the survey of providers and community groups and added several additional points to the list of strengths: the level of collaboration and partnerships between a cross-section of agencies; potential for new support from the newly elected provincial government; and innovative thinkers within the service system.

The group agreed with the weaknesses identified in the survey, further adding that a lack of cross-sectoral planning and collaboration on a region-wide basis causes service disruption and confusion. Lack of resources was another identified weakness.

Focus group participants identified additional funding from the new provincial government and integrated service systems/ministries as two possible areas of opportunity.

After reviewing the list of threats to the children's services system, focus group participants made some additions. Specifically, the lack of financial and human resources and concerns about service reductions were listed as threats.

Effectiveness of the system

A flip chart activity was completed to generate ideas for improving low ratings of system effectiveness from the survey of providers and community groups. Suggestions centred around increasing financial and human resources, improving the skill base of workers, effective community and regional initiatives (e.g., practical research, public education, political action to address regional inequities), increasing and improving services, and improving transportation and access for consumers.

Barriers

In general, some of the obstacles and barriers described by participants were consistent with comments from survey respondents, while others were unique. Barriers identified included out-of-pocket expenses for consumers, inconvenient service hours, and transportation issues. Wait lists, lack of services for outlying communities, and a lack of specialized mental health services and local mental health beds were also mentioned as barriers.

External Factors

The top external factors identified in the survey of providers and community groups were increased complexity of individual needs, availability of community supports, increased operating costs and the recruitment and retention of staff. Focus Group participants likewise highlighted the absence of local services due to a lack of federal and provincial funds and the increasing number of children exhibiting severe problems. In addition,

participants commented that public education can generate false positives and increase true positives, and expanded media coverage can have both positive and detrimental effects.

KEY INFORMANT PERSPECTIVES

Telephone interviews were conducted with 10 representatives from MCSS/MCYS sectors, related non-MCSS/MCYS sectors, regional and local government staff and provincial associations. The interviews covered broad contextual information about the children's and developmental services system. The comments made in these interviews are relevant to both sectors in all jurisdictions within the Hamilton Niagara region.

Trends

Key informants were asked to comment on trends, events, issues and professional practices in the children's and developmental services field. The informants commented that the change of government at the provincial level may have an eventual impact on policy related to children's and developmental services. The formation of a new children's services ministry could result in a more holistic view of the needs of children. The feeling was that this new ministry could signal a greater focus on children's mental health.

Furthermore, informants highlighted that the client base has diversified with more non-traditional populations now being served. Other trends related to a movement towards more interaction between ministries, as well as more integration and coordination at the agency level.

Regarding professional practices, informants reported that there is a movement towards accreditation and certification at the agency level and the utilization of evidence-based practices.

System SWOT analysis

Listed among the strengths of the children's and developmental systems identified by key informants was the wide array of services and supports available that are community-based and family/child centred. Informants added that services are not widely dispersed compared to other areas in Ontario. Another strength reported by informants is that agencies are flexible, responsive, exhibit a strong commitment to consumers, and possess a solid base of expertise.

Weaknesses identified in the children's and developmental systems included: service gaps; a focus on crisis rather than prevention; lengthy wait lists; difficulty transitioning into the adult system; inadequate communication between provincial government ministries; and the need for more sophisticated governance and management

infrastructures in some agencies. An additional weakness related to the lack of adequate funding and the existence of some "silos" and territorialism due to funding formulas. The high proportion of contract and part-time staff and the difficulty with recruitment/retention of staff due to lower salaries were also mentioned as weaknesses. Fragmentation and duplication was perceived as a weakness: several key informants pointed out that a "system" of children's and developmental services does not really exist – rather, there is a patchwork of individual programs. A final weakness noted was that children's and developmental services are not mandated in a similar way to that of child welfare and young offenders services.

Key informants had more difficulty coming up with potential opportunities in the children's and developmental services systems. One area of opportunity involved the possibility for agencies to adopt a more entrepreneurial stance and examine different ways of providing service. Other opportunities mentioned were research projects and grants, new funding initiatives (especially the funding influx through the Early Years Initiative), greater collaboration and partnering, and building on best practices.

System level threats identified by the key informants included the provincial deficit and its potential impact on funding levels, and an increasing amount of funding being directed to project or program areas (also known as 'targeted funding') rather than core funding resulting in a loss of flexibility on the part of agencies. Also mentioned was competition for funds with mandated services, such as child welfare, and "hard" infrastructure services at the municipal level.

A system "vision"

Key informants were asked to describe an "ideal" future system of children's and developmental services. The composite vision that emerged was comprised of many elements, including: a strong system with adequate resources and community supports; services delivered close to home; mandated children's and developmental services; extensive partnering among agencies within and across sectors; universally accepted systems of quality assurance; solid community planning with advance intelligence of emerging needs; and high levels of accountability and transparency.

SUMMARY

Common Themes

Nine major themes emerged from the data collected from the telephone interviews with families, the family focus groups, the survey of providers and community groups, the agency focus groups, and the key informant interviews. These themes appeared consistently in the open ended comments from the stakeholder groups and comprise the most salient issues confronting Niagara's children's mental health system at this time.

Resources

Lack of funding is mentioned consistently as a major area of concern, exacerbated by competition with mandated services such as child welfare. Additional funding is necessary to enhance services.

Collaboration

Increased linkages between agencies, Ministries, and service sectors are needed to improve service coordination and continuity. Transitional planning between children's and adult mental health services was specifically identified as an area that needs improvement.

Psychiatric Services – Inpatient and Outpatient

Psychiatric services are the most frequently identified future priority. Additional psychiatrists need to be recruited to Niagara. Likewise, psychiatric and mental health beds need to be available within Niagara's hospitals.

Residential Treatment

There is a lack of regionally based residential resources in Niagara. Enhancing residential services is seen as a future priority and suggestion for system improvement.

Access to Services

Transportation and the geographic location of services were perceived as the two greatest barriers to service. Consumers have difficulty accessing services as Niagara lacks a regional public transportation system.

Service Gaps

The supply of children's mental health/counselling services in general is outweighed by the demand, resulting in substantial waitlists. Further, there is a need for more specialized supports, e.g., dual diagnosis, autism.

Human Resource Shortages

Recruitment and retention of qualified, trained staff is a problematic issue, due in part to lower salaries. Elevated caseloads lead to staff burnout.

Early Intervention and Prevention

Increased early intervention and prevention programs are needed.

Duplication

Clarity required between Niagara Child and Youth Services and Contact Niagara regarding access and planning functions.

Key Questions

The experiences and perceptions of families, service providers and key informants presented in this section, serve to answer three of the key questions posed at the beginning of the planning process.

First, what are the identified strengths, weaknesses and pressures of the current service system? The input from families, service providers and key informants pointed to the following findings:

- The major strengths are: the quality of existing services and staff; the dedication, flexibility and responsiveness of service providers; families' satisfaction with the access process and with the appropriateness of referrals; the positive impact of services; collaborative service delivery; and strong partnerships.
- Weaknesses include: inadequate levels of service; service gaps and restrictions; inadequate financial and human resources, problems with the timeliness of services due to long wait lists; and fragmentation in the service system.
- Gaps in residential services, counselling, assessment/diagnosis and psychiatric services were identified.
- Obstacles and barriers to accessing services include: the geographical location of services and/or lack of transportation; consumers' out-of-pocket expenses; and problems with taking time off work or school because of the hours that services are offered.
- Insufficient financial resources, competition between agencies and sectors for funding, and a shortage of human resources were seen as key pressures or threats on the system.

Second, what should be the priorities for enhancing the current service system over the next three years? The input from service providers pointed to the following findings:

- Priorities for enhancements over the next three years should be: psychiatric services, residential services, assessment and diagnostic services, and counselling.

Third, where are the opportunities to address population well-being and achieve positive change within the current system? The input from families, service providers and key informants pointed to the following findings:

- The opportunities identified for achieving positive change within the Niagara children's system include: increased collaboration, expanding services to meet needs;

the potential for more funding and policy initiatives under a new government; and greater coordination of services at the local, regional and provincial levels.

The analysis of what people said about the service system completed the Community Study portion of this planning process. The Community Study – comprised of the Community Profile, the Review of the Service System and the Perspectives of Consumers, Service Providers and Key Stakeholders – supplied answers to all but one of the key questions posed at the beginning of the planning process. These answers would be further refined and the remaining question – “What requires further exploration?” – would be addressed through the next step in the development of this community service plan. This would be a community-based process established to formulate a vision, together with a set of priorities and goals for the Niagara community service plan.

Part Five:

Vision for Niagara Children's Mental Health Services

OVERVIEW

The next step in the community planning process was to create a vision, strategic directions and priorities for the next three years. This involved building upon the previous steps in the process - the collection and analysis of information about the Niagara community, the service system and peoples experiences with the system. All this information helped inform the community visioning process which included:

- The development of a shared three-year Vision (2004/05 – 2006/07)
- The identification of program priorities for the next three years
- The identification of priorities with respect to specific service design features and characteristics of the service continuum
- The identification of priorities related to established linkages to other local allied services as well as linkages to Hamilton-Niagara Regional office of Ministry of Community and Social Services (MCSS) and the Ministry of Children and Youth Services (MCYS)
- The identification of Year One Priorities within this broad three year set of Priorities

COMPASS Consulting Associates was hired to work with a community Reference Group to create the vision, strategic directions and prioritize goals for the next three years. The consultants developed a task and outcome oriented four-stage approach to assist in completing the visioning and priority setting component of the community service planning process. The first stage included creating a reference group and reviewing the

givens or the assumptions that would inform the process. The list of Reference Group Members is provided in Appendix Two.

The Reference Group was established to oversee the development of the vision, strategic directions and goals. Sixteen people, including one consumer, participated in the group. Agency representatives were comprised of senior managers and board members of MCSS/MCYS and related agencies. Included were: Niagara Child and Youth Services, Niagara Family and Children's Services Family Counselling Centre, Niagara Health System, Parents for Children's Mental Health, Niagara District School Board, Niagara Catholic District School Board, Family and Children's Services (FACS) Niagara, Centre de santé communautaire, and Mutual Supports. The Reference Group participated in four workshops, reviewed the information from the community study and participated in a joint workshop to discuss cross community issues.

The Reference Group established first principles, prepared a draft vision and a set of preliminary strategic directions and goals. Once this was completed, a community consultation was undertaken for consumers and agencies to review, strengthen and validate the work of the Reference Group. The final task of the Reference Group was to incorporate the community feedback and finalize the vision, strategic directions and goals, and set year one, two and three year priorities.

As the vision development process proceeded, the Reference Group identified several challenges. Many of these corresponded with the issues and challenges identified at the outset of the community planning process – tensions in expectations arising from the scope and scale of the plan, combined with limitations due to time constraints and the availability of data. The concerns raised by the Reference Group included some time delays in the community study, lack of confidence in the community data, concerns about the scope of the planning process and limited consumer involvement and that the planning process did not pay significant enough attention to other planning reports and processes. There was also concern that children's mental health funding had not increased. Each of these issues was addressed by Contact Niagara to the greatest possible extent, though not to the satisfaction of everyone involved.

Nevertheless, the Reference Group was able to move ahead with its tasks and proceed with the process of consulting further with the community as it formulated a vision and priorities based on the findings available from the earlier steps in the community planning process. It was noted that the challenges identified would serve as valuable lessons for future planning endeavours.

THE GIVENS AND FIRST PRINCIPLES

The first Reference Group workshop was held to review the givens and set the principles to guide the development of the vision. Reference Group members reviewed the community study information that was available, provided input into the planning givens

generated by the Contact agencies and the Ministry of Community and Social Services/Ministry of Children and Youth Services and identified the first principles to guide Reference Group planning, decision-making and recommendations.

MCSS/MCYS and the Contact agencies in Brant, Haldimand-Norfolk, Hamilton, and Niagara generated an approved list of givens to help guide the Community Planning processes and outcomes. These were reviewed and discussed by the Reference Group at the first workshop (See Appendix Four).

Reference Group members were also asked to develop first principles to help guide the development of Niagara children's mental health services. These first principles were used to help clarify the intent of the community service plan, make implicit values explicit, and eliminate incorrect assumptions on the part of both internal and external stakeholders. To help develop the principles, Reference Group members were asked to consider the following challenges:

1. How are we going to go about improving Children's Services in Mental Health Services in Niagara Region?
 - Maintain the Status Quo – some strengthening of current services, but not a great deal of change
 - Strengthen the Status Quo – less of some services, more of others, strengthen certain services, and introduce a few new services
 - Re-think Niagara's Children's Mental Health Services – almost everything is new

2. How will we determine the most appropriate allocation of Children's Mental Health Services resources in Niagara? (i.e. If we can't have everything we would like, then what?)
 - The greatest good for the greatest number
 - Those most apt to benefit
 - Those in greatest need
 - The most complete range of children's services along the promotion/prevention – amelioration/ treatment continuum

After discussing the advantages and disadvantages of each option Reference Group members agreed on the following First Principles:

First Principles Children's Mental Health Services

Strengthen the status quo – Enhance positive outcomes for children and families by envisioning a system of children and youth mental health services within an integrated sector; reviewing available data; strengthening and augmenting existing services and developing and implementing new services

In the allocation of Children's Services Resources in Niagara region we will seek to provide the most complete range of services along the promotion/prevention – treatment continuum

VISION DEVELOPMENT

Using the information generated in the first workshop as a touchstone, Reference Group members participated in exercises designed to support their development of a three-year vision statement. The vision statement describes Niagara's children's services future direction and what that system will look like three years from now. The vision will guide the development of the community service plan and will ensure that the service system is moving forward with a clear sense of purpose, consistency of action and an agreed-upon focus. The following was the result of the Reference Group's discussions:

Draft Vision Statement

Children and Youth of Niagara Region are provided with timely and effective mental health services that reflect a fully integrated, inter-ministerial approach (system), utilize best practices and respond to current and emerging needs in the context of the broader community

CROSS-COUNTY ISSUES

The Brant, Hamilton, Haldimand-Norfolk and Niagara Reference Groups for children's services (and developmental services) participated in a joint workshop on February 20, 2004. The intent of the workshop was two-fold:

- to learn about what was happening in other jurisdictions; and,
- to explore from a regional perspective a variety of issues identified in the community studies that could lend themselves to cross-boundary and/or cross-sectoral solutions.

It was hoped that these discussions would help to inform goal setting related to cross-county issues.

The afternoon session was organized according to sector i.e. two separate sessions, one for Children's Services and one for Developmental Services. Participants were organized accordingly.

The children's services group was challenged to explore cross-sectoral and/or cross-boundary innovations in children's service delivery. The full list of ideas can be found in Appendix Three: Cross County Issues. Some of the key issues identified included:

- Dual diagnosis - those children with both a developmental disability and mental health problems
- The need for respite services
- The transition from the children's mental health to adult mental health services
- The location of mental health services - services should be located where children are at (i.e. schools and other places children and youth gather)
- Lack of integration and the need to bring health, education and mental health together

A second challenge discussed by the children's services group focused on wait lists. Some of the key issues identified included:

- Strategies to reduce wait lists
- Supporting clients while on wait lists including crisis support/intervention
- Lack of psychiatric support/lack of psychiatrists in children's services

A third challenge discussed was the need for alternatives to residential treatment for children. Considerations included:

- Alternatives to residential treatment such as family preservation model, respite/relief, intensive child and family services ,
- Lack of residential treatment, children's early intervention programs and community outreach and children's mental health respite

COMMUNITY CONSULTATION

The final community study information, including supply and demand data, was presented in the fourth workshop. Using this information, as well as information generated in the previous workshops, Reference Group members participated in exercises to develop draft strategic directions and goals.

Following this workshop, the Reference Group undertook a community consultation to receive feedback on the draft vision, strategic directions and goals. Two consultation meetings were held for consumers and one for community agencies. No consumers attended the consultation sessions. Those service providers who attended completed a total of 18 consultation surveys. Consultation participants were also asked to comment on how they would prioritize the draft goals.

The consultation included an overhead presentation of key background information from the community study along with the vision and related strategic directions and goals.

A survey was subsequently distributed to each participant asking them to comment on the vision. People were asked if they supported, did not support or were undecided about each goal. They were also asked to prioritize each goal as a year one, two or three priority. The draft vision, strategic directions and goals along with feedback from the community consultation are summarized in Appendix Five.

THE VISION, STRATEGIC DIRECTIONS AND GOALS

The Reference Group reviewed the feedback from the consultation. The vision was changed based on the feedback and two strategic directions and related goals were eliminated and several other goals were revised. The final vision and the six agreed-upon strategic directions are as follows:

Vision

Niagara Region's Children, Youth, and Families are provided with timely and effective mental health services that reflect a coordinated, inter-ministerial approach, use best practices, and respond to current and emerging needs in the context of the broader community.

Strategic Directions

- A. A full spectrum of mental health services for children, youth and families
- B. Information supportive of successful planning and program development
- C. Effective use of technology in management and service delivery
- D. Continuous Improvement through inter-agency collaboration
- E. Accessible information regarding children's mental health Services
- F. Sustainable Funding

Strategic Direction A: A full spectrum of mental health services for children, youth and families

Goal Area: Residential Services

1. Work with other communities within Hamilton-Niagara region to develop specialized residential services. **(Year One)**
2. Increase Niagara's local residential capacity to meet the needs of the children of Niagara. **(Year One)**
3. Explore the feasibility of establishing permanent residential treatment beds in Niagara using fee for service residential dollars. **(Year Two)**

The Reference Group took the following findings into account when considering residential services:

- Families and individuals as well as service providers across Niagara believe that more residential treatment services are required. They described the system's wait list as well as its service capacity as obstacles to residential services.
- Enhancing residential services is seen as a future priority among stakeholder groups and a suggestion for system improvement.
- The average wait time for residential services is currently 5.8 months.
- As of March 31, 2004, the wait list for mental health residential services was 14 children and youth, representing 5.4% of the total number of referrals (260) waiting for services.

Goal Area: Counselling

4. Increase the capacity of counselling services in Niagara. **(Year One)**

Goal Area: Psychiatric Services

5. Increase the level of psychiatric services so that it meets at the least, the minimum provincial benchmark for a community the size of Niagara. **(Year One)**

Goal Area: Cross Sectoral Supports/Services

6. Ensure cross sectoral supports/services are in place to address the mental health needs of families and caregivers. **(Year One)**

The Reference Group took the following findings into account when considering counselling, psychiatric services and cross sectoral supports/services:

- Families and individuals as well as service providers believe that the lack of mental health counselling services represent a service gap that needs to be addressed.
- The system's wait list, as well as the system's service capacity, was described as an obstacle to the use of counselling services by families and providers of service. The supply is generally outstripped by the demand.
- For the fiscal year ending March 31, 2004, based on service requests through Contact Niagara, counselling was identified as the top referral category by service need at 64.6%, and the second top referral category by program type at 14.7%. If family intervention and single session were added to this latter percentage it would increase to 55.7%.
- The top program individuals were waiting for during the fiscal year ending March 31, 2004, was Child and Family Counselling (119), with an estimated wait list timeframe of 4.9 months.
- Lack of supports for more complex clients as well as gay, lesbian, bisexual and trans-gender youth were linked to this issue.
- Service providers will need to become more familiar with parent/caregiver issues. Service providers and key informants identified the use of evidence-based practices as an issue deserving of greater attention.

Goal Area: Transitional Age Youth

7. Identify and implement best practices related to cross-sectoral transitional age services. **(Year Two)**

The Reference Group took the following findings into account when considering transitional age youth:

- Service providers and key informants identified the use of evidence-based practices as an issue deserving greater attention
- Families and providers both noted that transitional age support services are needed in Niagara. Transitional age planning between children's and adult mental health services was also identified as an issue requiring attention.
- A review of documents relevant to Niagara's children's mental health community service plan identified several themes including the call for services and professionals to work together across sectors to develop and support an integrated and lasting response/solution that would include long term life span planning for clients. The need for protocols across sectors to support the transition process was also highlighted.

Strategic Direction B: Information supportive of successful planning and program development

Goal Area: Informed Picture of Services and Gaps

8. Develop an informed picture of service gaps and priorities to access and influence new funding, and influence its direction. This includes determining geographical location of needs and preparing an inventory of all current services (including French Language Services), identifying gaps and overlaps in current services. **(Year One)**
9. Using data from common assessment/baseline tools, undertake research to further understand needs and enhance community planning. **(Year Three)**

Goal Area: Coordinated Service Access

- 10.** Assess the location of services, location of clients, service delivery models and transportation needs, and explore alternative methods of providing interagency coordination across Niagara. **(Year Two)**

The Reference Group took the following findings into account when considering coordinated service access:

- Transportation and the geographic location of services were perceived as two of the greatest barriers to accessing services by families and providers.

Goal Area: Community Service Plan Impact

- 11.** The MCSS/MCYS Hamilton-Niagara Regional office will take into account Niagara's children's mental health community service plan to inform funding decisions. **(Year One)**

The Reference Group took the following findings into account when considering community service plan impact:

- Service providers reinforced the need for MCSS/MCYS to follow-up on the results and impact of community planning.

Goal Area: Youth Justice Legislation Impact

- 12.** Examine the impact of youth justice legislation on other programs (e.g. residential services). **(Year One)**

The Reference Group took the following findings into account when considering youth justice legislation:

- The review of documents relevant to children's mental health in Niagara identified the potential pressures that will be experienced by the system as a result of youth justice legislation.

Strategic Direction C: Effective Use of Technology in Management and Service Delivery

Goal Area: Information and Technology /Systems

- 13.** Identify what is required from a technology perspective to generate child specific information that can be shared across sectors. **(Year Three)**
- 14.** Identify opportunities to link current information systems to enhance individualized planning. **(Year Three)**
- 15.** Promote the need for a common information system for all children's services with the provincial government. **(Year Three)**

The Reference Group took the following findings into account when considering information technology/systems:

- The review of documents to help further inform children's mental health planning in Niagara identified the need for comprehensive technology management and coordination across the system.
- This same review also identified the call for system wide changes to support integrated life long planning and seamless service delivery.

Strategic Direction D: Continuous improvement through inter-agency collaboration

Goal Area: Common Assessment/Baseline Tools

- 16.** Reach agreement across all children's service providers on the use of common assessment/baseline tools for children's mental health. **(Year Three)**

The Reference Group took the following findings into account when considering common assessment/baseline tools:

- The review of documents relevant to children's mental health in Niagara identified the need to identify and eliminate barriers to collaboration. The need for a single and coordinated assessment process was noted.

Goal Area: Mutually Supported Planning and Decision Making

17. Develop an inter-agency approved and provincially sanctioned process/mechanism to facilitate efficient, collaborative, mutually supportive planning and decision making on an ongoing basis. **(Year One)**

The Reference Group took the following findings into account when considering mutually supported planning and decision making:

- Reports summarized in the review of documents relevant to children's mental health in Niagara identified a clear focus on collaboration and coordination, along with region wide planning, as essential to an effective children's mental health system.
- There is a need for Niagara Child and Youth Services and Contact Niagara to discuss the scope and focus of their respective planning processes.

Goal Area: Increased Psychiatric and Psychological Supports and Services

18. Work together to develop a recruitment strategy that results in increased psychiatric and psychological supports and services in Niagara Region. **(Year Two)**

The Reference Group took the following findings into account regarding increased psychiatric and psychological supports and services:

- Psychiatric services were the most frequently identified service priority by both families and service providers.
- It was further noted that psychiatric and mental health beds are needed in Niagara's hospitals.

Goal Area: Coordinated Services to Address Pervasive Developmental Disorders

19. Coordinate across service sectors to meet the needs of children and youth with pervasive developmental disorders (autism spectrum disorders). **(Year One)**

The Reference Group took the following findings into account when considering coordinated services to address pervasive developmental disorders:

- Psychiatric services were the most frequently identified service priority by both families and service providers.
- It was further noted that psychiatric and mental health beds are needed in Niagara's hospitals.

Goal Area: Coordination of French Language Services

20. Increase capacity of children's mental health services to the French community through collaborative work between Centre de sante communautaire and other children's agencies. **(Year One)**
21. Develop protocols to ensure coordination of French Language Services in Niagara. **(Year One)**

The Reference Group took the following findings into account when considering the coordination of French language services:

- The review of documents relevant to children's mental health in Niagara identified the call for system wide changes that support integrated service responses, including coordinated access to mental health services for French speaking children.
- This same review identified the need for protocols with respect to a variety of areas.

Goal Area: Ongoing Learning

22. Develop formal and informal linkages between children's mental health agencies and centres of research and learning. **(Year Two)**

Goal Area: Maximize Best Practices

23. Collaborate across agencies and sectors to identify/share strategies, results and related outcome measures used by each agency, to maximize best practices. **(Year One)**

The Reference Group took the following findings into account when considering ongoing learning and best practices:

- Niagara's service providers focused on the use of evidence-based practices as an area that merited attention and some improvement.
- The reports summarized in the review of documents relevant to children's mental health community service planning in Niagara highlighted values that included evidence based treatment and outcome based practices as well as research and program evaluation.

Strategic Direction E: Accessing Information about Children's Mental Health Services

Goal Area: Informed Client /Families

- 24.** Develop communication tools that provide an integrated perspective to clients regarding children's mental health services in Niagara. **(Year One)**
- 25.** Develop and implement public awareness strategies to better inform parents about transitional issues. **(Year Two)**

The Reference Group took the following findings into account when considering informed client /families:

- Individuals and families as well as service providers identified the need for more public education regarding mental health issues and services.
- The effective management of client transitions emerged regularly as an issue in the community study as well as in the review of documents relevant to children's mental health community service planning.

Strategic Direction F: Sustainable Funding

Goal Area: Multi-Year Funding

26. Develop a strategy to influence government policy toward multi-year funding. **(Year One)**

Goal Area: Increased Funding

27. Advocate for increased funding to base budgets to address identified mental health needs in Niagara. **(Year One)**
28. Advocate for increased funding to meet the needs of the Youth Justice Act. **(Year One)**

The Reference Group took the following findings into account when considering increased funding:

- Inadequate resources and funding were identified extensively by all stakeholder groups.
- Key informants noted the increasing amount of funding being directed to projects vs. core funding, resulting in a loss of flexibility on the part of agencies and reducing their ability to plan.
- The review of documents relevant to children's mental health in Niagara identified the potential pressures that will be experienced by the system as a result of youth justice legislation.

Goal Area: Funding Reflective of Niagara's Determinants of Health

29. Advocate for planning and allocations that take into account Niagara Region's determinants of health in addition to child population statistics. **(Year One)**

The Reference Group took the following findings into account when considering increased funding reflective of Niagara's determinants of health:

- The number of adults with less than a high school education is greater in Niagara than in the Hamilton Niagara Region or the province.
- Low income is associated with higher risk of health problems and lower quality of life:
 - 13.2% of Niagara's population have incomes below the Low Income Cut Off, compared to 11.7% provincially
 - Niagara's median income is lower than the provincial median for all families

Part Six:

Conclusions

The completion of this community service plan represents the fifth and final step in an extensive and inclusive process that involved fact finding, community consultations, analysis of information from multiple sources and the far-sighted deliberations of Reference Group members who brought all this together by creating a vision, strategic directions and goals.

It was always envisaged that this plan would be a starting point. The information collected and the conclusion reached will not only serve to guide the service system over the next three years, but also provide a baseline for future planning endeavours. The process as a whole can also serve as a learning experience, as the community looks for ways of improving upon the information gathering, consultation and consensual decision-making approach that went into developing this plan.

The vision and strategic directions that were created through this planning process are comprehensive and inclusive. They involve extending the reach of the service system to respond to a wide range of community needs. They are also designed to build the capacity of the service system with better data, improved practices, enhanced opportunities for collaboration, and stronger links with the broader community and other service sectors.

The task that lies ahead for all involved is to continue working together to make this vision a reality. The completion of this plan is not the end, but only a beginning.

Appendix One

Framework for Children's Mental Health Services

HIGHLY SPECIALIZED SERVICES & SUPPORTS

(Services & supports that address the most severe and complex needs of children and youth; may be located in the community or regionally)

Psychiatric Support & Consultation	Acute Care Hospitalization	Crisis Treatment
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ACCESS SERVICES

- Coordinated Information
- Intake
- Referral
- Service Resolution
- Planning

RESIDENTIAL SERVICES

(Part of a continuum of children's mental health services, provided as close as possible to a child's home and community)

Respite	Associate Family/ Parent Model	Group Care/ Residential Treatment	Crisis & Stabilization	Specialized Services
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CORE SERVICES

(Services & supports that provide a broad range of service options that are located in each community, close to consumers and responsive to the community's needs)

Crisis / Treatment	Home / School Based Services	Assessment / Clinical Services
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Appendix Two

Reference Group Members

Children's Services

Niagara Community Planning Reference Group Participation List

AGENCY	PARTICIPANT 1	PARTICIPANT 2	PARTICIPANT 3
Adhoc	Rhonda Clarke-Bruyn MCSS/MCYS Bill Matheson Chair Contact Niagara Steve Novosedlik and Don Campbell Contact Niagara		
(currently) Niagara Child and Youth Services (formerly) Niagara Centre for Youth Care and Niagara Child Development Centre	Linda Langston Executive Director	Bill Helmezi Director of Clinical Services	Evelyn Bergen Board Member
Family & Children's Services Family Counselling Centre	Bill Charron Executive Director Catherine Mindorff Board Member	Bonnie Filipchuk Supervisor Family Counselling Centre	Dori Madar Director Community Services
Centre de sante communautaire	Michele Renaud Director, Centre Clinique Dr Renaud	Adele Tanguay Director, Programs & Services	

AGENCY	PARTICIPANT 1	PARTICIPANT 2	PARTICIPANT 3
Ontario Association of Residences Treating Youth	Dave Schulz Executive Director Mutual Support Systems of the Niagara Region	Frank Christie Clinical Coordinator Ausable Family Services	
Niagara Health System	Judith Tompkins Regional Director – Mental Health		
Niagara Health System	Dr. Ken Santher		
Parents for Children’s Mental Health Niagara	Carol Hall		
District School Board Niagara	Margaret Jordan Educational Resource Centre Psychologist		
Niagara Catholic District School Board	Andre Ceci Program Officer Student Services		

Appendix Three

Cross-County Issues and Innovative Responses

A) Explore cross-sectoral and/or cross-boundary innovations in Children's service delivery

1. Dual Diagnosis – developmental services and mental health

- Consultations between front line service providers
- Adapt ART Adult dual diagnosis training to children's sector
- Include this ART dual diagnosis training in DSW program and other professional training (i.e. RN, SW, GP)
- Transitional program for 16-18 year olds for housing, sheltered employment, day programs (Chedoke)

2. Respite Services

- Build on Developmental Services respite system for children's services
- Include Relief services to children's mental health, i.e. Special Services at Home (SSAH)
- Children with complex needs require regular, consistent, planned respite with more flexibility
- Parent developed respite (i.e. physical space excess and pool SSAH \$ to provide)

3. Transition Children to Adult Mental Health services

- Education component needs attention

4. Location of services

- Community-based children's mental health services in schools and other areas where kids gather, close offices?

5. Lack of integration

- Bring health, education and mental health together

6. Other

- Support children to get post-secondary education that meets their needs
- Prevention and early intervention
- Best Practices
- Sustainability
- Training – new research
- Access to BCFPI
- Innovation
- Assess resources across boundaries, what is needed, equitable access to resources
- Critical thresholds

B) Wait Lists – Reducing Wait Lists and supporting clients while they are on Wait Lists

1. Wait Lists

- Walk-in Clinics, single session “consults”, up to 3 sessions
- Wrap around “miniwraps”
 - Use of other community resources, formal and informal
- Routine access to BCFPI information
- Using BCFPI data to prioritize and direct to appropriate services
- Create low cost high volume evidence based treatment modalities across agencies for the whole community
- Free up therapeutic time by increasing the effectiveness and efficiency of therapy interventions
- Prioritize (risk assessment)
- Lesser intervention/support groups
- Short burst (front end service)
- Diversion at the front end

2. Supporting clients while on Wait Lists

- Crisis support/intervention – short term case management
- Walk-in Clinics
- Parent Resource/Information Nights re issues while on Wait Lists
- Parent Groups
- Information – videos, books, articles
- Case Management while on Wait List

3. Lack of psychiatric support/lack of psychiatrists in Children’s Services

- Strategies to recruit/attract child psychiatrists
- Tele-psychiatry
- Borrow models from other countries re use of tele-psychiatry and resource distribution
- System management of sessional funding (e.g. adult)
- Matching question/concern to expertise
- Increasing Ministry partnerships to address issue
- Equitable access to regional resources
- Acceptance that a mental health problem is a health problem worthy of the same attention as any other health problem. Presently there is no policy for the provision of children’s mental health. Policy and resources are needed province wide
- Balancing what the community needs in terms of services and what individuals want for their career aspirations
- Use of other health care professionals in the absence of psychiatrists
- A Plan for Psychiatric Education and Service for the Province of Ontario

- Commission a provincial review of access to mental health service
- Consider levels of service/risk in designing local community services – who provides what is essential

C) Children’s Residential Alternatives – Alternatives to residential treatment for children, A lack of residential treatment for children, Other?

1. Alternatives to Residential Treatment

- Family preservation model
- Respite/Relief
- Intensive Child and Family services
- Partnerships
- Case Management of children within all the services
- Prevention programs
- Looking at the child as part of the system
- Family mentoring
- Day treatment
- Supports for families while waiting for residential services
- Regional beds

2. Lack of Residential Treatment

- Regional access to beds
- Prioritize
- Single point of access (one Wait List)
- Other alternatives/restructure what we have at this point

3. Other

- Be aware of all the resources presently out there (funded and private sector, e.g. recreational, support groups)
- Best Practices

4. Lack of children’s early intervention programs and community outreach

- We (Hamilton, Brant Haldimand-Norfolk) are not doing badly in the area of early years prevention.....BUT regarding Adolescents the following are needed:
 - Greater coordination
 - More involvement in schools, mental health, pediatricians
 - Early assessments (opportunities) regarding risk factors
 - Continuing present programs
- Lack of resources, both funding and staff
- Funds are currently for targeted groups
- Lack of awareness of existing programs
- Need for evaluation of parents/community regarding symptoms etc.

- Link with education – early identification and intervention

5. Lack of children’s early intervention programs and community outreach

- YCJA – empty beds, service reallocation, training
- Regional planning across boundaries – i.e. mental health, custody, probation, child welfare, etc.

6. Lack of children’s mental health respite

- Need to define respite (everything from programs to overnights?)
- Partnering with “Y’s” or Recreation for after school or weekend
- Offer respite to:
 - The school
 - The family (all members as prevention)
- SSAH going into the home and not leaving the home
- Use volunteer families

Appendix Four

MCSS/MCYS Planning Process Givens

GIVENS

Community Services and Supports

1. Highly specialized services and supports (i.e. services and supports that address the most complex needs of children) may be located at the community or regional level, depending on the size of the population and the critical mass needed to provide the services in an economical fashion.

Financial Resources

2. Since demand for services outstretches resources, priority setting is required.
3. Community planning should not be expected to result in additional dollars.
4. Resources can shift to accommodate a shift in service focus and approach.

Process

5. Community service planning is an iterative process that will evolve over time based on improved quality of data along with feedback from community stakeholders.
6. The Reference Group will determine the community service plan recommendations to MCSS/MCYS, the local community, agency providers and other funders informed by stakeholder input and recognizing that consumers have a wide variety of needs.
7. All decisions/recommendations are to be tested against the analysis of consumer input.
8. The process is open to a variety of outcomes, e.g. amalgamation, changes in service levels.
9. Regional Office Program Supervisors will attend local Reference Group Workshops as an observer/resource.
10. Regional Office will not direct the outcome of the process beyond this list of givens.
11. The process will work toward a consensus but where consensus cannot be achieved it will be noted.
12. Money cannot be moved between Children's Services and Developmental Services.

Outcomes

13. Reference Group decisions/recommendations must be consistent with the summarized findings.
14. Community service plans will seek out and develop cross county/regional solutions to issues, where appropriate.
15. Community service plans will inform MCSS/MCYS Regional Planning and help with resource allocation decisions as well as local planning at the agency and community level.
16. A community service plan will help ensure that communities are well positioned to respond to new funding and program directions as they emerge.

17. Future negotiations between transfer payment agencies and the Ministries will consider the recommendations included in the community service plan along with other relevant factors.
18. The Regional office will formally respond to the community service plans by September 2004 and will provide a status update annually thereafter.
19. Contact Agencies will coordinate communities in monitoring, evaluating and updating the community service plan annually.
20. The needs of the community, as opposed to the needs of the agency will inform the Plan.
21. The community service plan focuses on the system as opposed to individual agencies.

Transition

22. The intent of this process is to be as creative and innovative as possible recognizing the need for reasonable and supportive transition and change.
23. Change will happen using a planned and respectful process based on short and long term goals.

Appendix Five

Consultation Feedback

NIAGARA REGION COMMUNITY SERVICE PLAN:

CHILDREN'S MENTAL HEALTH SERVICES

VISION

Children and youth of Niagara Region are provided with timely and effective mental health services that reflect a fully integrated, interministerial approach (system), utilize best practices and respond to current and emerging needs in the context of the broader community.

COMMENTS:

Families need to be included ✓✓✓✓✓

Replace fully integrated with:

- multi disciplinary ✓✓✓✓
- coordinated ✓✓✓
- both of the above ✓✓

Add Relevant ✓✓✓✓

Plan should include all children's services or will be inconsistent with the vision ✓✓

Include idea of helping children and youth reach their full potential

Replace "provided" with "supported"

Too long and bureaucratic

STRATEGIC DIRECTIONS & GOALS	HOW DO YOU FEEL ABOUT EACH STRATEGIC DIRECTION & GOAL?			PRIORITIES (✓) *		
	Support	Do Not Support	Uncertain	Year 1	Year 2	Year 3
	<p>A. <u>Strategic Direction:</u></p> <p>A full spectrum of mental health services for children, youth and families</p>					
Draft Goals – Residential Services				*75% agreed on year one priority		
1. Work with other communities within Hamilton-Niagara region to develop specialized residential services.	16	-	1	5	4	3
2. Increase Niagara's local residential capacity to meet the needs of the children of Niagara	16	-	-	9*	3	-
3. Explore the feasibility of establishing permanent residential treatment beds in Niagara using fee for service residential dollars.	14	1	3	5	4	2
COMMENTS						
<ul style="list-style-type: none"> • Bed issue is being addressed by NHS – communication important • Whose dollars will be involved? • Need to explore why the use of residential beds is increasing – location of complementary out patient services insufficient/inaccessible? 						
Draft Goals – Counselling Services				*86% agreed on year one priority		
4. Increase the capacity of counselling services in Niagara.	17	-	-	13*	2	-
COMMENTS						
<ul style="list-style-type: none"> • Need more qualified professionals e.g. psychotherapists • Funding for French Language counselling required 						

STRATEGIC DIRECTIONS & GOALS	HOW DO YOU FEEL ABOUT EACH STRATEGIC DIRECTION & GOAL?			PRIORITIES (✓) *		
	Support	Do Not Support	Uncertain	Year 1	Year 2	Year 3
	*85% agreed on year one priority					
Draft Goals – Psychiatric Services						
5. Increase the level of psychiatric services so that it meets at the least, the minimum provincial benchmark for a community the size of Niagara.	15	-	-	11*	2	-
COMMENTS	<ul style="list-style-type: none"> Funding for at least one bilingual psychiatrist required Need to address other issues that will attract psychiatrist to the Region (salaries, working conditions, university program) Medication critical to many for successful outcome 					
Draft Goals – Transitional Age Youth						
6. Identify and implement Best Practices related to cross-sectoral transitional age services.	16	-	1	8	4	3
COMMENTS	<ul style="list-style-type: none"> Immediacy of this issue needs to be considered 					

STRATEGIC DIRECTIONS & GOALS	HOW DO YOU FEEL ABOUT EACH STRATEGIC DIRECTION & GOAL?			PRIORITIES (✓) *		
	Support	Do Not Support	Uncertain	Year 1	Year 2	Year 3
	<p>B. Strategic Direction: Information supportive of successful planning and program development</p>					
<p>Draft Goals – Informed picture of services and gaps *86% agreed on year one priority</p>						
<p>7. Develop an informed picture of service gaps and priorities to access and influence new funding, and influence its direction:</p> <ul style="list-style-type: none"> • Determine geographical location of needs • Prepare an inventory of all current services (including French Language Services), identifying gaps and overlaps in current services. 	17	-	-	12*	2	-
<p>COMMENTS</p> <ul style="list-style-type: none"> • Determine additional costs of providing French Language Services that are the equivalent of English Language Services • Fort Erie – very needy re mental health services • Agencies always seem to be preparing inventories of service- how does this relate to role of Information Niagara? 						
<p>Draft Goals – Informed picture of services and needs</p>						
<p>8. Using data from common Assessment/Baseline tools, undertake research to further understand needs and enhance community planning.</p>	16	-	2	6	3	2
<p>COMMENTS Caution regarding too much process and insufficient action</p>						

STRATEGIC DIRECTIONS & GOALS	HOW DO YOU FEEL ABOUT EACH STRATEGIC DIRECTION & GOAL?			PRIORITIES (✓) *		
	Support	Do Not Support	Uncertain	Year 1	Year 2	Year 3
	Draft Goals – Coordinated Service Access					
9. Assess the location of services, location of clients, service delivery models and transportation needs, and explore alternative methods of providing interagency coordination across Niagara.	16	-	2	6	4	1
COMMENTS						
<ul style="list-style-type: none"> Fort Erie, Port Colborne and other poverty pockets need immediate attention Transportation very important consideration – request that Province take some leadership here 						
Draft Goals – Community Service Plan Impact						
10. The MCSS/MCYS Hamilton-Niagara Regional office will take into account Niagara Children's Mental Health Community Service Plan to inform funding decisions.	13	-	2	6*	-	2
COMMENT						
<ul style="list-style-type: none"> Pre-supposes N-H Regional Office has control independent of Central Control 						
Draft Goals – Youth Justice Legislation Impact						
11. Examine the impact of Youth Justice legislation on other programs (e.g. residential services).	15	-	2	4	6	1
COMMENTS						
<ul style="list-style-type: none"> Work closely with Child Welfare on this goal Request more counselling services Alternative resources will be essential – beds, supports counselling Huge area of opportunity to intervene appropriately with kids 						

STRATEGIC DIRECTIONS & GOALS	HOW DO YOU FEEL ABOUT EACH STRATEGIC DIRECTION & GOAL?			PRIORITIES (✓) *		
	Support	Do Not Support	Uncertain	Year 1	Year 2	Year 3
	<p>C. <u>Strategic Direction:</u></p> <p>Effective use of technology in management and service delivery</p> <p>Draft Goals – Information Technology/Systems</p> <p>12. Identify what is required from a technology perspective to generate child specific information that can be shared across sectors.</p> <p>13. Identify opportunities to link the current information systems to enhance individualized planning.</p> <p>14. Promote the need for a common information system for all children's services with the provincial government.</p> <p>COMMENTS</p> <ul style="list-style-type: none"> • Common information system not needed – what is required is a common terminology and ability to work together • Different programs and agencies have different needs – • Provincial direction needed to support/guide this and make it happen 					
18	-	-	1	4	6	
17	-	-	-	5	6	
15	2	-	4	3	4	

STRATEGIC DIRECTIONS & GOALS	HOW DO YOU FEEL ABOUT EACH STRATEGIC DIRECTION & GOAL?			PRIORITIES (✓) *		
	Support	Do Not Support	Uncertain	Year 1	Year 2	Year 3
	<p>D. Strategic Direction: Continuous Improvement through inter-agency collaboration</p> <p>Draft Goals – Common Assessment/Baseline tools</p> <p>15. Reach agreement across all Children’s Mental Health service providers on the use of common Assessment/ Baseline tools.</p> <p>COMMENTS</p> <ul style="list-style-type: none"> Has been done Front line staff have to have a solid understanding of how front line services relate – need opportunities to network with one another <p>Draft Goal – Mutually Supported Planning and Decision Making</p> <p>16. Develop an inter-agency approved and provincially sanctioned process/mechanism to facilitate efficient, collaborative, mutually supportive planning and decision making on an ongoing basis</p> <p>COMMENTS</p> <ul style="list-style-type: none"> Mental health services are provided by other sectors as well therefore coordinated planning needs to ensure it works with other Regionally/Provincially sanctioned processes 					
16	-	2	4	4	4	4
17	-	-	5	6	1	1

STRATEGIC DIRECTIONS & GOALS	HOW DO YOU FEEL ABOUT EACH STRATEGIC DIRECTION & GOAL?			PRIORITIES (✓) *		
	Support	Do Not Support	Uncertain	Year 1	Year 2	Year 3
Draft Goals – Increased Psychiatric and Psychological Supports and Services						
17. Develop and implement strategies for sharing resources in order to increase psychiatric and psychological supports and services.	16	-	1	8	2	3
COMMENTS						
<ul style="list-style-type: none"> Need more psychiatrists and outpatient support before we open more beds 						
Draft Goals – Coordination of French Language Services	*75% agreed on year one priority					
18. Increase capacity of Children’s Mental Health services to the French community through collaborative work between Centre de sante Communautaire and other children’s agencies.	13	2	3	6*	-	2
19. Develop protocols to ensure coordination of French language services in Niagara.	13	2	2	5	-	3
COMMENTS						
<ul style="list-style-type: none"> Identify and add funding required to provide French Language Services equivalent to English Language Services All languages and cultures need to be considered 						
Draft Goals – Ongoing Learning						
20. Develop formal and informal linkages between Children’s Mental Health agencies and centres of research and learning.	17	-	-	1	7	3
Draft Goals – Maximize Best Practices						
21. Collaborate across agencies and sectors to identify/share strategies, results and related outcome measures used by each agency, to maximize best practices.	16	1	-	-	5	3

STRATEGIC DIRECTIONS & GOALS	HOW DO YOU FEEL ABOUT EACH STRATEGIC DIRECTION & GOAL?			PRIORITIES (✓) *		
	Support	Do Not Support	Uncertain	Year 1	Year 2	Year 3
	E. <u>Strategic Direction:</u>					
Accessible information regarding Children's Mental Health Services						
Draft Goals – Informed Client/Families						
22. Develop communication tools that provide an integrated perspective to clients regarding Children's Mental Health Services in Niagara.	16	-	1	4	2	3
23. Develop a publicly accessible database identifying current services such as counselling and residential services.	13	-	4	3	3	4
24. Develop and implement public awareness strategies to better inform parents about transitional issues	13	-	2	6	1	3
COMMENTS						
<ul style="list-style-type: none"> • Look at existing system and those under development to avoid duplication • Information should be available in French & English • Link with other data bases related to children's services 						
F. <u>Strategic Direction:</u>						
Funding flexibility						
Draft Goals – Increased Flexibility						
25. Increase flexibility to purchase services across sectors.	15	1	1	7	3	-

STRATEGIC DIRECTIONS & GOALS	HOW DO YOU FEEL ABOUT EACH STRATEGIC DIRECTION & GOAL?			PRIORITIES (✓) *		
	Support	Do Not Support	Uncertain	Year 1	Year 2	Year 3
	<p>G. <u>Strategic Direction:</u></p> <p>Competitive wages and Benefits</p> <p>Draft Goals – Wages and Benefits Information</p> <p>26. Collect and analyze salary and benefit information across children’s agencies/sectors in Niagara.</p> <p>COMMENTS</p> <ul style="list-style-type: none"> Waste of time if Ministry not committed in advance to addressing this issue 					
<p>H. <u>Strategic Direction:</u></p> <p>Sustainable Funding</p> <p>Draft Goals – Multi - Year Funding</p> <p>27. Participate in multi-year planning that will be used to influence government policy toward multi-year funding.</p> <p>Draft Goals – Increased Funding</p> <p>28. Advocate for increased funding to base budgets to address the reductions and shortfalls over the last ten years.</p> <p>COMMENTS</p> <ul style="list-style-type: none"> Only where efficiencies can’t be reached through other means Need to advocate for stabilization dollars 						

STRATEGIC DIRECTIONS & GOALS	HOW DO YOU FEEL ABOUT EACH STRATEGIC DIRECTION & GOAL?			PRIORITIES (✓) *		
	Support	Do Not Support	Uncertain	Year 1	Year 2	Year 3
	*75% agreed on year one priority					
Draft Goals – Increased Funding						
29. Access funding to expand Youth Justice programs to meet current needs.	13	-	4	6*	2	-
Draft Goals – Risk Factors						
30. Advocate for planning and allocations that take into account societal issues and risk factors.	16	-	-	5	4	3
COMMENTS						
<ul style="list-style-type: none"> Should be reflected in the funding formula base budget Also needs to take geography and cultural distribution into account 						

An analysis of issues identified in the Community Study was completed. If Issues were identified by two or more Stakeholder Groups, or were identified in three or more categories and are not addressed by a Community Service Plan Goal, they are listed below.

Specialized Services e.g. Autism; Dual Diagnosis; Early Intervention and Prevention; Hours of Service/Taking Time Off Work; Community Support Services

- 1. If you would like to see either of the above issues addressed in a Community Service Plan Goal please identify the issue below.**
- 2. Are there any areas of concern that are not addressed? If there are any other issues that you would like to see addressed through a Community Service Plan Goal please identify them below**

Specialized services

- A primary concern – should not have been excluded
- Specialized services need to be addressed in plan
- Include autism

Coordination/collaboration

- Coordinate plan with sectors/services not included – child welfare; autism; fee for service residential – should have been included to begin with ✓
- Coordinate with MOHLTC
- Interface with addictions/treatment system
- Specific goal needed re cross-sectoral collaboration
- Children's Mental Health and School Board need to communicate better in order to meet needs of children requiring special services – explore partnerships to share psychiatric services

Prevention and early identification services need to be addressed in plan ✓✓✓

- Stabilize funding for these programs-strengthen families and build communities

French Language Services

- Stronger wording needed for French language services – recognize “need to be equivalent to French Language Services”
- Apply French Language consideration to all areas where there are gaps

Idea of bench marks for French speaking population – look to other ministries for direction

Transition Aged Youth Issue

- Multi-dimensional
- Welfare issue – 16 years
- Consistency re understanding/definition of adult

Alternative funding sources need to be explored

Need to evaluate current service – do we need more of the same/more options/different programs that may be more efficient/effective?