

Children's Services SYSTEMS REPORT

for April – September 2011

1. CHILDREN'S MENTAL HEALTH AND DEVELOPMENTAL SERVICES WAIT LISTS

Following are the total number of children and youth waiting for services by program as of September 30, 2011. The 2nd column provides the number of new referrals in 2011 - 2012, and the 3rd column is the number of children that were waiting as of March 31, 2011.

This data is based on the number of referrals completed by Contact Brant, and is also dependent on service providers' notification of admissions.

Children's Services Wait Lists							
	Wait 09/30/11	New 11-12	Wait 03/31/11		Wait 09/30/11	New 10-11	Wait 03/31/11
CAS Alternate Care	29	5	28	SLCS C&Y Garden Group	4	5	0
CPRI Residential CDS/CMH	2/6	1/5	3/8	SLCS SNAP Group	8	12	n/a
CPRI Outpatient	7	3	15	SLCS Youth Anger Group	0	37	n/a
FCC Behaviour Consult.	5	16	3	SLCS Respite Camp	19	29	25
FCC FamilyRelief Day/Respite	21	5	17	SLCS YRC Long-term	0	5	0
FCC Family Support	5	9	5	WMHAS C&F Counselling	137	233	186
FCC - Groups	2	3	n/a	WMHAS Waitlist Clinic*	n/a	81	n/a
LCC Autism - IBI	31	27	14	WMH DayTreatment EDT/ADT	1/2	4/2	2/4
LCC ABA (new August 2011)	49	66	n/a	WMHAS Early Years	6	13	18
LCC Infant/Child Develop.	9	88	14	WMHAS Home-based	17	29	32
LCC Respite: In-home	25	31	26	WMHAS Residential	2	5	5
LCC Respite: KidsCountry Inn	8	8	3	WMHAS Wraparound	7	3	6
LCC Respite: Autism	60	22	53	WMH Temper Tamers Group	19	21	n/a
LCC Respite: Kids First	9	12	4	Triple P (WMH/SLCS/FCC/OEYC)	119	141	n/a
McMaster Child. Hospital	34	7	n/a	Other Regional programs**	17	9	10

*Priority referrals to Woodview Child & Family Counselling are made related to the risk of harm to self or others, according to a clinically-defined need, and are referred directly to the Waitlist Clinic; others wait listed drop-in.

**Regional Programs: Lynwood Hall (Respite/Complex Needs Bed, Residential Treatment, & Charlton Hall; Woodview Canada House; Niagara Child & Youth Services; and CPRI HomeShare.

Acronyms: ABA = Applied Behaviour Analysis

CAS = Children's Aid Society of Brant

FCC = Family Counselling Centre of Brant

SLCS = St. Leonard's Community Services

SNAP = Stop Now and Plan

C&F = Child and Family Counselling

EDT/ADT = Elementary or Adolescent Day Treatment

WMHAS or WMH = Woodview Mental Health and Autism Services

IBI = Intensive Behavioural Intervention

CPRI = Child and Parent Resource Institute

LCC = Lansdowne Children's Centre

C&Y = Child and Youth Garden (Group)

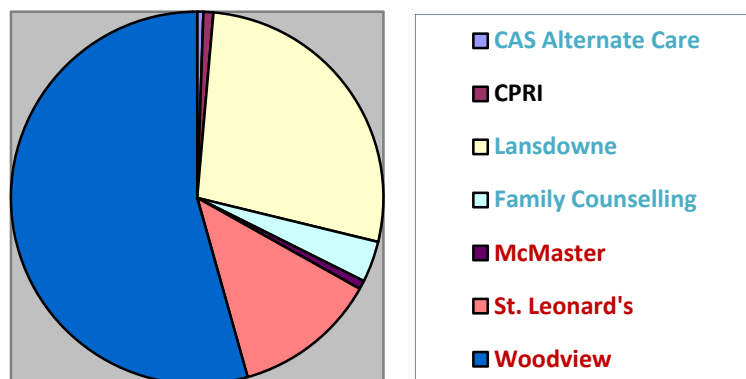
YRC = Youth Resource Centre

Triple P = Positive Parenting Program

a. Distribution of Referrals by Agency:

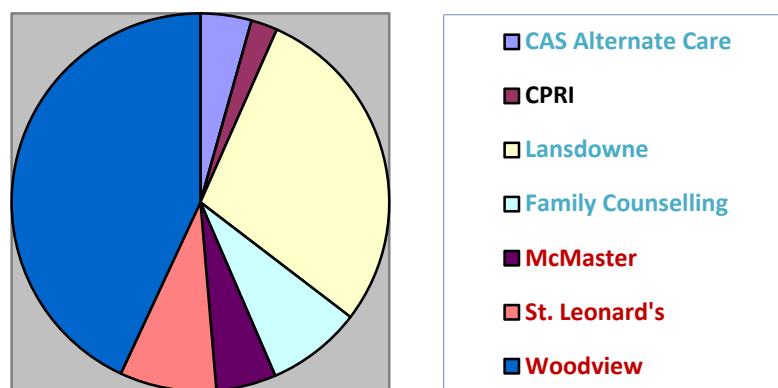
Children’s Mental Health (CMH) services are provided by **Woodview, St. Leonard's, and McMaster**; Children’s Developmental Services (CDS) are provided by **Lansdowne, Family Counselling, and CAS** Alternate Care Respite; CPRI provides CMH and CDS. 68% of referrals were to Children’s Mental Health programs and 32% were to Children’s Developmental Service programs which is different than previous years where the ratio was closer to 75% - 80% CMH to 25% - 20% CDS. The new Lansdowne Applied Behaviour Analysis (ABA) program spiked intakes in August-September as families were informed it was first come/first served.

Following is the [distribution of referrals by agency](#) for April 1 to September 30, 2011.



b. Distribution of Wait List by Agency:

Following is the [distribution of wait list by agency](#) for April 1 to September 30, 2011. The following information is impacted by the new MCYS funding to address children’s mental health waiting lists at Woodview, as well as the new ABA initiative at Lansdowne that received a large influx of referrals before the services actually started. Note: The data from CPRI and McMaster are not accurate as reporting is not received regularly.



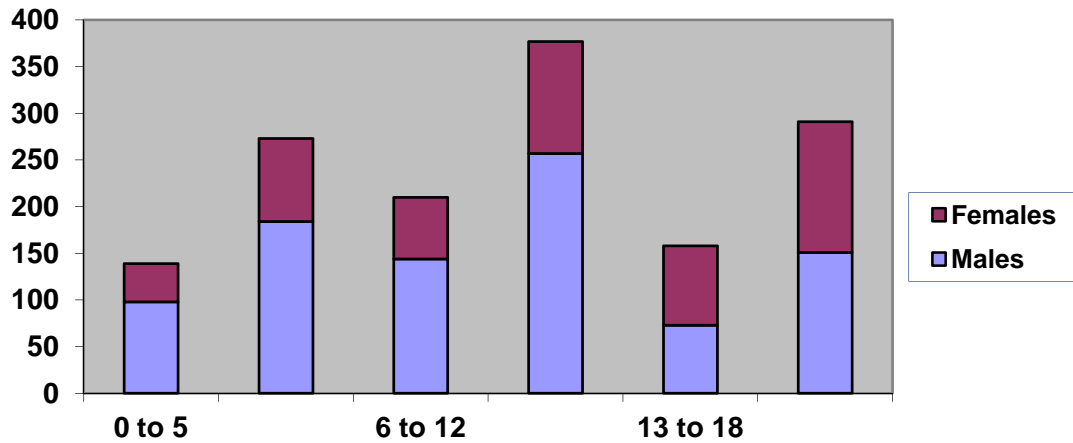
c. Unique Children and Youth:

The number of intakes is not the same as the number of referrals. One intake can result in the referral to several services, or a child could return during a fiscal year to be referred to another service and another intake is required if the situation has significantly changed (otherwise a referral can be made based on the intake information on record). In 2011 – 2012, the [number of unique children and their families](#) was **556**; 507 are unique children referred to services while the remainder represents unique parents/caregivers referred to groups only. The [number of referrals to services](#) was **985**; of these, 758 were referrals for children/youth and the remainder to parenting groups only.

d. Sex and Age of Children at Intake for 2011 - 2012:

The first column in each age group reflects the sex of children intakes were completed for from April 1 to September 30, 2011.

The 2nd column in each age group compares 2010 – 2011 data for the fiscal year.

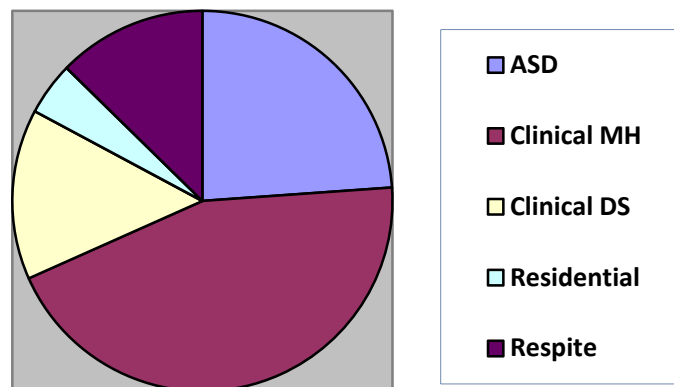


Males represent 62% and females represent 38% of the children/youth that went through intake in 2011 – 2012; this is consistent with the previous year. 71% of the age 0 – 5 age group referrals were males which is a 4% increase to the previous year; 69% of the age 6 – 12 age group referrals were males which is consistent with the previous year; 46% of the 13 – 18 age group referrals were males - previous years have reflected the ratio of males to females seems to equalize in the adolescent years.

The 6 – 12 age group, representing 41% of the children/youth, is the largest age group at intake. The 13 – 18 age group represents 31% of the children/youth at intake, and the 0 – 5 age group represents 28% of the children/youth at intake. This pattern of age groups is similar to previous years.

e. Referrals in 2011 – 2012 by Service Needs:

Following is the proportion of referrals according to categories of service needs.



- ASD services specifically provide supports for children with Autism Spectrum Disorder. The implementation of ABA services at Lansdowne resulted in a spike in referrals for August/September as services are provided on a first come, first served basis. Of the ASD services, 22% are respite services (not included in the Respite numbers) and the remainder are clinical (IBI and ABA – not included in Clinical DS numbers).
- Clinical Mental Health (MH) programs include CPRI outpatient, McMaster, and all Woodview services except their residential treatment program.

- Clinical Developmental Services (DS) are primarily services for children with a developmental disability at Family Counselling (Behaviour Consultation, Family Support programs); includes Lansdowne Infant and Child Development program.
- Residential programs include residential treatment programs at CPRI, Woodview, and regional services, as well as the St. Leonard's Youth Resource Centre (YRC) long-term program. The residential treatment services are for children with mental health issues and or high behavioural support needs.
- 71% of Respite services available to Brant are for children with a developmental disability; the St. Leonard's Respite program serves mainly children with mental health issues. In addition to this data, the ASD services provide respite which would change this ratio to 80% respite services available in the children's developmental sector compared to 20% in the children's mental health sector. It should be noted that this data may not reflect the need for respite for children with mental health concerns as respite services are not available for referral.
- These stats do not include information on the Brant community's Crisis Services which include Woodview Crisis Response, Six Nations Mobile Crisis Response, and St. Leonard's Walk-in Clinic, nor the Woodview Telepsychiatry Services; all would be considered clinical mental health services that are funded by MCYS.
- These stats also do not include services provided at Six Nations and New Credit that are funded by MCYS, which would also be considered clinical mental health services.

f. Presenting Profile for Referrals to Services in 2011 - 2012:

Waiting lists identify children waiting for services and their prioritization status, but also summarize the profile of the children and youth. Following is the presenting profile for males and females referred to services April 1 to September 30, 2011, as well as the prevalence this profile reflects in overall referrals. Cooperativeness, Attention/Impulsivity and Family Dynamics are the profiles with the highest rates, followed by Anxiety, Social Functioning, and Conduct/Behaviours. This is consistent with the previous year.

Profile of Children/Youth at Intake by Sex and Prevalence							
	Female	Male	Overall		Female	Male	Overall
Abuse (witness/abused)	33	36	15%>	Dual Diagnosis	1	6	1%
Aggression	33	77	24%>	Family Dynamics	88	121	45%>
Anxiety	95	99	40%>	FASD/query	4	10	3%
Attention, Impulsivity	73	151	48%>	First Nations	6	10	3%
Autism (ASD)	13	40	11%	Justice involvement	4	6	2%
Accessibility/Barrier free	1	0	-	School Issues	32	67	21%>
Bullied/Bullying	33	50	18%>	Self Injurious Behav.	22	14	8%
Communication	15	40	12%	Sexual Acting Out	3	12	3%
Complex Health	6	1	1%	Social functioning	61	114	38%>
Conduct/Behaviours	68	104	37%>	Substance Abuse	14	8	5%
Cooperativeness	90	144	51%>	Visual or Hearing	2	2	-
Depression	73	60	29%>	Witness to Violence	37	50	19%>

Note: > indicates that the percentage of children/youth presenting with these issues has increased significantly over last year.



Considering **males** represent 62% and **females** 38% of the referrals, it is interesting to note some of the ratios in these presenting profiles:

- Females represent 55% of the children/youth presenting with depression issues; 39% of all females and 22% of all males presented with depression
- Females represent 61% of the those presenting with issues of self harm; 12% of all females and 4% of all males presented with self injurious behaviours
- Females represent 64% of those presenting with substance abuse; 8% of all females and 3% of all males presented with substance abuse issues
- Females represent 86% of those presenting with complex health issues; 3% of all females presented with complex health issues
- Males represent 60% of those presenting with being bullied or bullying; 18% of all males and 18% of all females presented with being bullied or bullying
- Males represent 68% of those presenting with school issues; 24% of all males and 17% of all females presented with school issues
- Males represent 67% of those presenting with attention/impulsivity 55% of all males and 39% of all females presented with attention/impulsivity
- Males represent 70% of children/youth presenting with aggression issues; 28% of all males and 18% of all females presented with aggression issues
- Males represent 60% of those having involvement with the justice system; 2% of all males and 2% of all females presented with involvement with justice
- Males represent 71% of those presenting with FASD or FASD query; 4% of all males and 2% of all females presented with FASD/FASD query
- Males represent 73% of those presenting with communication difficulties; 14% of all males and 8% of all females presented with communication difficulties
- Males represent 75% of those presenting with Autism Spectrum Disorder; 14% of all males and 7% of all females presented with ASD
- Males represent 57% of those presenting as being a witness to violence; 18% of all males and 20% of all females presented with being a witness to violence
- Males represent 52% of those presenting with concerns of abuse; 13% of all males and 18% of all females presented with concerns of abuse.
- Males represent 51% of those presenting with anxiety; 36% of all males and 51% of all females presented with anxiety.

g. Profile of Those Waiting for Services

Is the profile of those waiting for services as of September 30, 2011 the same as those referred to services? Is there any significance related to the profiles that have an increased or decreased prevalence at the time of intake compared to waiting lists?



Children and youth may have been placed on the waiting list prior to the start of the fiscal year. Admissions to some services rely on Prioritization based on clinical need, and other services depend on the Length of Time on the wait list. These factors impact who is on the waiting list. Some may also have received a service related to their primary need and are now waiting for another service.

Note: < indicates that the percentage of children/youth waiting with these issues has decreased significantly over last year
> indicates that the percentage of children/youth waiting with these issues has increased significantly over last year

Profile and Prevalence of Children/Youth <u>Waiting</u> for Services							
	Female	Male	Overall		Female	Male	Overall
Abuse (witness/abused)	17	29	11%<	Dual Diagnosis	6	7	3%
Aggression	26	79	26%<	Family Dynamics	62	89	37%
Anxiety	52	81	33%	FASD/query	9	9	4%
Attention/Impulsivity	49	101	37%	First Nations	11	12	6%
Autism (ASD)	26	108	33%>	Justice involvement	8	15	6%
Accessibility/Barrier Free	3	2	1%	School Issues	25	49	18%
Bullied/Bullying	19	45	16%	Self Injurious Behav.	21	11	8%>
Communication	29	96	31%>	Sexual Acting Out	6	10	4%
Complex Health	6	7	3%	Social functioning	44	116	39%>
Conduct/Behaviours	42	81	30%>	Substance Abuse	7	8	4%
Cooperativeness	62	114	43%	Visual or Hearing	3	4	2%
Depression	45	39	21%	Witness to Violence	26	44	17%>

- Males represent 65% of children and youth waiting for services and females represent 35% - this is fairly close to the ratio for referrals (62% to 38%) although a greater percentage of males are waiting.
- The same six issues lead the prevalence rate of profiles for those waiting for services: Cooperativeness, Attention/Impulsivity, Family Dynamics, Anxiety, Social Functioning, and Conduct/Behaviours.
- The profiles that reflect an increase (of 2% or more) from the rate at the time of referral compared to the rate for the wait list include the following: ASD (22% - likely due to new ABA program), Communication (19%), First Nations (3%), and Justice Involvement (4%).
Is there any significance that the ratio of children and youth who have identified having a First Nations heritage increased by 3% for those waiting for service compared to those at the time of referral?
- The profiles that reflect a decrease (of 2% or more) from the rate at the time of referral compared to the rate for the wait list were Abuse (4%), Anxiety (7%), Attention/Impulsivity (11%), Conduct/Behaviours (7%), Cooperativeness (8%), Depression (8%), Family Dynamics (8%), and School Issues (3%).

h. Profile of Aboriginal Children and Youth at Intake

Two First Nations communities, the Six Nations of the Grand River and Mississaugas of New Credit, are within the County of Brant; additionally there is a significant urban aboriginal population. Not surprisingly, Brant has a higher aboriginal population than the province of Ontario. Residents of the First Nations communities may choose services

from their own community or from the broader Brant community. The data from Contact Brant is based on those who choose to access services from Brant agencies and does not include data from Six Nations or New Credit services as they complete their own intake. Although identification of native heritage is asked at intake, information is limited to those who self-identify. There were 41 children and youth who completed an intake in 2011 – 2012 who identified with a First Nations status; the following data is limited.

Profile of Aboriginal Children/Youth at Intake					
	#	Overall		#	Overall
Abuse (witness/abused)	12	29%	Dual Diagnosis	2	5%
Aggression	15	37%	Family Dynamics	19	46%
Anxiety	15	37%	FASD/query	7	17%
Attention, Impulsivity	15	37%	Justice involvement	3	7%
Autism (ASD)	3	7%	School Issues	7	17%
Accessibility/Barrier free	0	-	Self Injurious Behav.	9	22%
Bullied/Bullying	12	29%	Sexual Acting Out	2	5%
Communication	6	15%	Social functioning	12	29%
Complex Health	0	-	Substance Abuse	2	5%
Conduct/Behaviours	16	39%	Visual or Hearing	0	-
Cooperativeness	20	49%	Witness to Violence	11	27%
Depression	12	29%			

- 66% were male and 34% were female. There is a higher ratio of aboriginal males at intake compared to the broader Brant population (62%).
- 85% were referred to children’s mental health services; 20% were referred to children’s developmental services - 25% of these had a dual diagnosis. This varies from the broader Brant data where the ratio was 68% to children’s mental health to 32% to children’s developmental services this fiscal year, although previous years were closer at 75% to 80% to children’s mental health services.
- 7% of aboriginal children were prioritized as “emergent” at intake (*see Section 3a*)
- Cooperativeness and Family Dynamics, then Conduct/Behaviours, Aggression, Anxiety and Attention/Impulsivity are the profiles with the highest prevalence. This is similar, but with some variance, from the broader Brant data, where the profiles with the highest prevalence were Cooperativeness, Attention/Impulsivity, Family Dynamics, Anxiety, Social Functioning, and Conduct/Behaviours.

i. Intake and Service Coordination for 2011 - 2012:

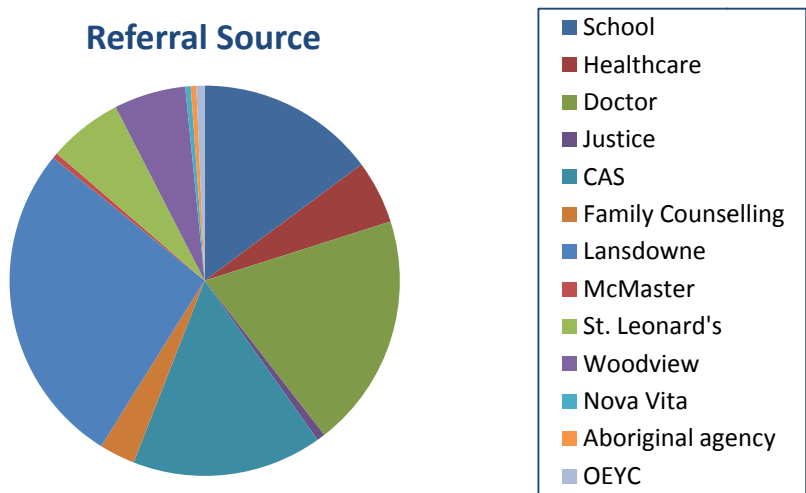
Following is the data for April 1 to September 30, 2011 related to Contact Brant’s mandates of completing intakes and referrals, as well as on-going coordination of services, including Case Resolution in the children’s services sector.

Total Intakes/Service Coordination	10,192
Total Intakes/Requests	871
Total Children’s Case Resolution Reviews	9
Total RPAC’s	5

The intake data represents 18% of the intakes completed in the Hamilton-Niagara Region, and 17% of the unique children presenting to the Contact agencies in the region.

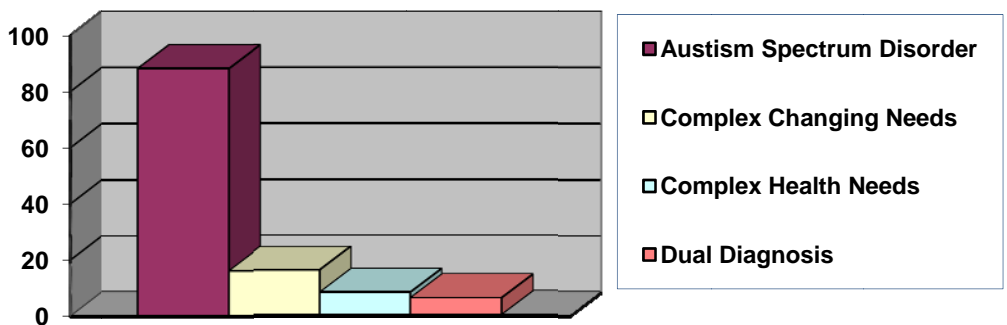
j. Referral Source

New information has started to be gathered regarding what organization suggested that a family call Contact Brant to access services. Following is baseline data for the referral source gathered at intake by those who identified a resource:



k. Wait Lists by Ministry Areas of Interest:

The Ministry has historically asked for information on several groups. Following is the 2011 – 2012 waiting list data related to children under age 18 in these identified groups.



- Autism Spectrum Disorder (ASD) are complex developmental disorders characterized by deficits in social interaction, social communication, and unusual and/or repetitive behaviours; the severity of the symptoms vary greatly. Research estimates 1 in 165 children have ASD (less than 1%). The above stats are impacted by the implementation of the ABA program; by September 30th, services had not been fully implemented but referrals were accepted starting mid-August.
- Complex Changing Needs reflects those children with complex and multiple needs requiring specialized services and supports to participate in day-to-day activities on a long-term, continuous and/or intermittent basis, with two or more special needs requiring an integrated cross-sector service approach. The complexity of the service needs of the child is often supported by such programs as Wraparound.
- Complex Health Needs reflect those children and youth considered medically fragile; many of these children are technologically dependent.
- Dual diagnosis reflects those with both a developmental disability and mental health issues. Research indicates the prevalence of individuals with a developmental disability having a dual diagnosis is at least 30%.

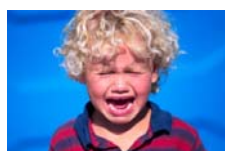
2. CHILDREN RECEIVING SERVICE IN 2011 - 2012:

a. In-Service Statistics

Following are the number of children and youth receiving services from April 1, 2011 to September 30, 2011; the total units of service is 1,006. The 2nd column is the number of children admitted to services in this time period - the total number of admissions has been 348. The 3rd column is the number of children admitted to services in 2010 – 2011. *This data is dependent on service providers' notification of admissions and discharges.*

Children Receiving Service							
	In Service	Admits 11-12	Admits 10-11		In Service	Admits 11-12	Admits 10-11
CAS Alternate Care	28	4	7	SLCS Group C&Y Garden	n/a	0	0
CPRI Residential CMH/CDS	4/0	4	21	SLCS Group SNAP	n/a	11	n/a
CPRI Outpatient	n/a	n/a	n/a	SLCS Group Youth Anger	n/a	23	n/a
FCC Behav. Consultation	61	13	38	SLCS Respite Camp	117	9	59
FCC Family Relief Day/Respite	27	0	12	SLCS YRC Long-term	3	0	2
FCC Family Support	23	6	17	WMH C&F Counselling	158	75	113
FCC - Groups	n/a	n/a	n/a	WMHAS Waitlist Clinic	n/a	72	n/a
LCC Autism - IBI	18	2	6	WMH Day Treat.- EDT/ADT	8/9	/2	3/1
LCC ABA	n/a	n/a	n/a	WMHAS Early Years	25	12	20
LCC Infant/Child Develop.	196	34	96	WMHAS Home-based	25	17	27
LCC Respite: In-home	89	17	15	WMHAS Residential	15	7	8
LCC Respite Kids Country Inn	52	2	8	WMHAS Wraparound	13	2	6
LCC Respite: Autism	67	13	11	WMH Temper TamersGroup	n/a	27	n/a
LCC Respite: Kids First	n/a	9	2	Triple P Groups	n/a	87	n/a
McMaster Inpatient/outpatient	1/1	n/a	18/116	Other Regional programs	3	2	1

Note: McMaster's in-patient data is based on April 2010 to January 2011 and out-patient on April 2010 to March 2011; out-patient services include Day Hospital, Outreach and Urgent Access.



b. Crisis Response Services

[Woodview Mental Health and Autism Services Crisis Response](#) provides telephone counselling support as well as mobile response when needed to children, youth and their families who are experiencing a mental health crisis; Woodview Crisis Response Services are available 7 days per week from 9:00 a.m. to 9:00 p.m.

Additionally, [Six Nations Crisis Response](#) provides similar services 24/7 to children, youth and their families residing at Six Nations of the Grand River.

Brant children, youth and their families also have access to the [St. Leonard's Community Services Walk-in Clinic](#) at 225 Fairview Drive. The community can access these services directly Monday to Thursday 11:00 a.m. to 6:00 p.m.

Following is data received from the service providers for April 1 to September 30, 2011:

Woodview Crisis Response					
	11-12	10-11		11-12	10-11
Crisis calls on weekends	33	86	Crisis calls to hospital	22	37
Crisis calls 9 a.m. – 5:00	134	342	Crisis calls go mobile	32	31
Crisis calls 5 – 9:00 p.m.	86	218	Average phone call (minutes)	27	19.5
After hours calls*	11	15	Average mobile call (hours)	1.61	1.8
Total calls	254	649	Average hospital call (hours)	2.38	2
Unique callers	139	380	Number of hours total	153	456
Note: *Only 1 'after-hours caller' left a message for follow-up in 2011-12, and 3 in 2010-11.					
St. Leonard's Walk-In Service					
Direct client contacts	81				

c. Telepsychiatry Services

The Ontario Telepsychiatry videoconferencing program provides children, youth and their families with access to clinical consultations with a child psychiatrist without having to leave their local community. It also provides community agency staff with consultation and training to build their professional expertise to improve their practice.

Woodview Mental Health and Autism Services provide access for the Brant community to the [Paediatric Telepsychiatry Program](#) through teleconferencing with the Western Hub located at CPRI. The Telepsychiatry service is available to children up to age 18 who would benefit from a psychiatric consultation, as determined by a mental health agency or physician. The service provides one time consultations; these do not need to be at a tertiary level. A clinician/case manager is required to attend the consultation with the client. A report is sent to the referent and identified physician for follow-up.

Following is information related to [usage](#) for April 1 to September 31, 2011 as well as the previous fiscal year.

Telepsychiatry Services		
	2011-12	2010-11
Psychiatric Consultations	9	21
Program Consultations	1	8
Educational Sessions	2	6

Following is the [profile of children accessing telepsychiatry](#) consultations – ADHD, Anxiety, School problems, and Sleep problems are the most prevalent profiles.

Profile of Children/Youth Accessing Telepsychiatry Consultations								
	11-12	10-11		11-12	10-11		11-12	10-11
Developmental delay	4	2	Antisocial behavior	3	2	Somatization	3	3
FAE/FASD	0	0	Conflict with law	1	1	Eating disorder	0	0
Socialization	4	8	Sexual acting out	0	2	Sleep problems	7	8
School problems	7	13	Mood problems	6	9	Family conflict	4	7
ADHD	7	12	Suicidal behaviour	2	3	Strange/bizarre behavior	0	3
ODD	5	10	Self-harm	3	6	Witnessed trauma	2	1
Aggression	5	10	Anxiety	7	10	Experienced trauma	4	4

3. CHILDREN WITH COMPLEX NEEDS – PRIORITY AND PLANNING:



a. Children and Youth Prioritized as Urgent or Emergent: 56

'Urgent' are children/youth identified at risk due to services and family supports having been exhausted; the service system cannot meet all the child's needs.

'Emergent' are children/youth identified as not having sufficient supports available in community to meet their needs and their service needs are stressing the service system as well as the family system; often the child's living at home may be in jeopardy, or their supervision needs are not easily met.

Following is a summary of the profiles of the 56 children and youth prioritized at the urgent or emergent levels on September 30, 2011. These children are in-service and/or waiting for services:

- 5% (3 youth) are identified as 'urgent' and received Regional Complex Needs Funds to meet their needs for specialized supports; the remainder are 'emergent'
- 54% are identified with depression
- 54% are identified with conduct/behaviours
- 52% are identified with cooperativeness issues
- 50% have a developmental disability and 50% of these children are identified as having a dual diagnosis; all 3 identified as 'urgent' have a developmental disability
- 48% are identified with attention/impulsivity
- 45% are identified with issues regarding social functioning
- 41% are identified with anxiety
- 38% are involved with CAS Brant
- 30% are identified with Autism Spectrum Disorder
- 21% are identified as having been abused
- 16% are identified with sexually acting out behaviours
- 14% are identified with problems in the area of family dynamics
- 14% are identified as having been a witness to violence
- 11% are identified as aboriginal; only 3% of all new referrals have First Nations heritage. Of all the children identifying as aboriginal, 7% were prioritized as 'emergent'.
- 5% are noted as having involvement with the justice system
- 1 is medically fragile

Reminder!

Please have staff call Contact Brant to **update the "priority" status** of individuals you support if they are at the "**emergent**" or "**urgent**" level
(Refer to Community Service Collaboration Protocol for definitions)



b. Planning for Youth with a Developmental Disability:

According to the Transitional Aged Youth with a Developmental Disability Protocol, Brant children’s service providers, adult developmental service providers, and other sectors must coordinate plans for youth with a developmental disability to address realistic plans at age 18 when children’s services end. A regional Transitional Aged Youth Protocol is anticipated to be developed this fiscal year; information received to date sets expectations that are very similar to Brant’s current Transitional Aged Youth Protocol:

- **Planning is to begin at age 14** by ensuring the youth is identified to Contact Brant for an intake and to provide information about transition planning.
- It is especially important for Crown Wards (TAY) and Complex Needs Youth (CNY) to have coordinated plans
- The Children’s Case Resolution Protocol identifies TAY’s and CNY’s transition plans are reviewed at Case Resolution at age 16 and again at age 17 to ensure coordinated **plans are in place by age 18**.

What will each youth really do when they age out of children’s services? Together, children’s and adult service providers need to develop unique plans for each youth considering appropriate activities, places to live, and community supports. Children’s service providers need to develop a discharge plan from their services and also need to inform adult service providers about what each youth needs to make the various parts of the support plan successful. Adult providers need to contribute to the development of the transition plan to identify what services or supports they can provide within funded services and address creative options when services are not available. **It is important that transition planning develop realistic plans including alternatives to adult services where vacancies are extremely limited.**

As of July 1st, the Developmental Services Ontario Hamilton-Niagara Region (DSO) has become part of the transition planning. Youth should be referred to the DSO at age 16 to start the eligibility process and information about adult services.

Following is the number of youth with a developmental disability, by priority, who are registered at Contact Brant that require transition planning over the next few years.

Transition Planning for Youth with a Developmental Disability						
	Age 18 in 2011 - 12	Age 18 in 2012 - 13	Age 18 in 2013 - 14	Age 18 in 2014 - 15	Age 18 in 2015 - 16	Age 18 in 2016-17
TAY	1	3	3	1	0	0
CNY- Funded	1	0	0	0	1	0
CNY- Priority	2	7	1	1	0	3
Total TAY/CNY	4	10	4	2	1	3
Other Priority	5	13	14	11	6	12
Total	9	23	18	13	7	15

CNY-Funded = Complex Special Needs-funded; CNY-Priority = Emergent or Urgent and not CNY-funded; Other Priority = all other prioritizations, i.e., ‘Maintaining’ or ‘Percolating’

c. Children's Case Resolution Reviews:

There were 10 Case Resolution reviews for 9 unique children from April 1 to September 30, 2011. An additional youth was reviewed in the previous fiscal year for supports and funding this year; this brings the total unique children supported this year through Case Resolution recommendations to 10.

- Three (3) youth were identified as complex needs youth (CNY), all with a developmental disability, considered at risk and requiring specialized supports funded through the Regional Complex Needs Fund; all three are receiving residential supports out of county
- Three (3) youth are crown wards (TAY) with a developmental disability who had their transition plans reviewed.
- Four (4) were complex needs youth (CNY) with a developmental disability who had their transition plans reviewed.



4. GAPS/PRESSURES AND INITIATIVES IN THE CHILDREN'S SERVICE SYSTEM:

a. Gaps and Pressures

The Children's Services Committee engaged stakeholders in a system planning session in June 2011. Information was presented on a Stakeholder Survey, wait list data, current resource allocations, and children's mental health-funded programs outcome data. The planning session identified an exponential increase in service demand/wait lists; it also resulted in some priorities being identified, as well as recommendations for next steps. Recommendations from the breakout groups are now being further addressed by the Children's Services Committee in the areas of:

- ✓ Information and Outcome Measures
- ✓ Collaborative Service Delivery
- ✓ System Funding Recommendations
- ✓ Child and Youth Mental health Fund.

Following are excerpts from the Planning Day Report by David Sheridan, Shercon Associates. Conclusions related to gaps and pressures from the breakout groups:

- Wait Lists: We need to improve wait list times to get the necessary services to the children of our community when they need those services; there are too many kids waiting for services; there has been an exponential increase in demand/supply, longer wait lists; we need more counselling services to meet wait list demand
- Length of Wait: The 2009 cuts from the Brant CAS related to purchases of children's mental health services had an impact on quickness of service delivery.
- Practice: We need to look more broadly at our current services for collaborations for treatment/referral services; there is a need for increased collaboration, coordination across services and Ministries.
- Gaps: Gaps exist in clinical assessment and treatment for complex mental health (psychiatry, psychologist, social workers – MSW qualified); improved diagnostic

service (including ongoing psychiatry involvement) to effectively direct management

- Aboriginal Youth: There is a disproportionate amount of high risk aboriginal youth (on and off reserve) (MH, justice, education)
- Investment: Mobile and walk-in crisis response investment is high in Brant – Woodview Crisis Response/Mobile, Six Nations Crisis Response/Mobile, St. Leonard’s Walk-in. How many are repeat users? What’s the unit cost?

Gaps and pressures have also been identified in 2011 – 2012 through Intake, Case Resolution, or at the Children’s Services Committee:

- Triple P - Need for more Triple P Groups (groups have been received well and waiting lists are continue to be large). Funding for the Triple P Parent Workbooks is needed at a cost of approximately \$2,500 per year (based on running 8 groups).
- Overnight and/or extended full-time respite in Brant is still needed to meet the demands of children and youth with a dual diagnosis or for those who are medically fragile; this would have benefited three youth who have been placed out of county
- Respite - There remain no respite options for children with complex behaviour/mental health issues and no urgent response respite programs.
- Transitional aged youth planning - Children’s services end at age 18 and similar levels of support especially related to developmental respite or accommodation services are not readily available in adult services. Improvement in planning for this transition is needed by community service providers and should address unique alternative supports for each youth.
- Step-down transition plans are needed when transitioning a child home from a residential treatment placement; plans need to be well coordinated, and creative supports may need to be considered.

b. Brant System Initiatives 2011 - 2012

At the Planning Day it was recognized that as a community we have been creative in dealing with wait lists (e.g., wait list clinic, single sessions/different modalities, triaging, and recognizing needs); we have an improved, more detailed and inclusive data base; and our pressures have led to a reassessment of service delivery, (i.e. prioritizing services and wait list clinic).



Following are initiatives implemented in 2011 – 2012 in the children’s services sector:

- Triple P Seminars (Positive Parenting Program) started in the Fall of 2011 in addition to the 8-week Triple P groups already offered to parents; the coordination of Triple P by Woodview Children’s Mental Health & Autism Services, St. Leonard’s Community Services, Family Counselling Centre, Ontario Early Years Centre Brant, New Credit Health & Social Services, and Contact Brant continues to be seen as a successful community-driven initiative.

- Applied Behaviour Analysis Services and Supports (ABA) initiative funding was received by Lansdowne Children's Centre for implementation in the Fall of 2011; the interest has been great for this new service as reflected in the wait list.
- Children's Mental Health Wait List Reduction - Woodview Mental Health & Autism Services received funding for new staff specifically to address wait lists; this combined with the Wait List Clinic implemented last year has had a significant impact on those waiting for children's mental health services.
- Mental Health Workers in Schools - Woodview received information that they will be funded to implement the mental health workers in schools initiative; this is part of the provincial mental health strategy and will be collaboratively implemented with the two school boards.
- Your Guide – The number of organizations financially supporting and submitting information for this publication continues to grow. Your Guide is recognized as a valuable resource for families and service providers; 25,000 copies are distributed three times annually in Brant, Haldimand and Norfolk to provide information on free workshops, courses, groups and events for children, youth and their families. Brant organizations supporting Your Guide this fiscal year include:
 - Ontario Early Years Centre Brant
 - Woodview Mental Health and Autism Services
 - Best Start
 - Brant County Health Unit
 - Family Counselling Centre of Brant
 - Children's Aid Society of Brant
 - Brantford Public Library
 - Lansdowne Children's Centre
 - Contact Brant
 - Brant Haldimand Norfolk Catholic District School Board
 - Grand Erie District School Board.

For more information on this report, call Contact Brant (519) 758-8228