CHILDREN AND YOUTH DESERVE MORE:
MOVING TO A CHILD, YOUTH AND FAMILY-CENTRED SYSTEM OF CARE FOR CHILDREN AND YOUTH WITH SEVERE MENTAL HEALTH ISSUES

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Doing Better for Children and Youth with Severe Mental Health Problems

CMHO members are very concerned because we know that too often children and youth receiving residential treatment do not have their needs met and do not achieve better outcomes. Too many children, youth and families experiencing severe mental health challenges have uncertain outcomes, and inconsistency in access and care across the province.

This must change and is an urgent priority for our members as access to intensive treatment in community settings is at-risk of declining further in the near-term. Paradoxically, healthcare policy reform is identifying the need for increased intensive community care to reduce hospital utilization rates.

CMHO members eagerly awaited the Ontario government’s Residential Services Panel report because we believed it would be an important catalyst for much needed change. However, we are concerned that the breadth of the Panel’s mandate meant they did not identify the targeted changes required to improve outcomes for children and youth in residential mental health treatment.

CMHO members support the Panel’s strong focus on improving quality and accountability; embedding child, youth and family voice in all aspects of treatment and system planning; addressing gaps in workforce education and training; and delivering treatment based on data, evaluation and research to ensure positive outcomes. See Appendix A for a detailed analysis. We have developed a Roadmap for Change which builds on the Panel’s recommendations and integrates them with CMHO’s deepened focus on mental health treatment, including the right implementation sequence for this part of the residential services system given its unique context and challenges.

CMHO members believe a paradigm shift, supported through government funding and policy change is needed to meet the needs of children and youth with severe mental health problems. This paradigm shift must focus on:

- **The development of a provincial system of intensive treatment**: Move away from use of residential treatment as the last point on a linear continuum, and operationalize 24/7 out-of-home treatment as a component of a ‘system of care’ – a specialized intervention accessed as part of an overall treatment plan, not a final destination. Invest in a suite of intensive services to realize the ‘system of care’ so that children and youth with severe mental health problems have community options beyond hospital and 24/7 out-of-home treatment; and

- **Supporting child, youth and family-centred care**: Shift the focus to treating children and youth in the context of their families and/or caregiving contexts. Evidence is unambiguous about the critical role of families/caregivers in child and youth mental health and development, and we cannot drive to strong outcomes without treating children and youth with their families/caregivers whenever possible.

CMHO members are concerned the government response may be to implement new legislation, licencing changes and accountability mechanisms, and then stop the work there. Although these changes are necessary, they are not sufficient to drive change in the mental health residential treatment system. Rather, long-term work over successive
government fiscal and policy making cycles is what our services require to deliver treatment outcomes for children, youth and families.

We are pleased the Ministry of Children and Youth Services (MCYS) has made it a first priority to develop a blueprint for residential services, and we offer a “Roadmap to Change” to help clarify the levers that will create change in the mental health residential treatment component of the system. CMHO members are committed to working with MCYS, children, youth, and families and all stakeholders to collaboratively and boldly reshape intensive treatment services for children and youth.

**A System of Care for Intensive Services is Urgently Needed**

Residential treatment exists as an important part of a continuum of mental health services for a small number of children and youth with severe needs who require intensive treatment. This population of children and youth are frequent users of hospital services, both emergency department (ED) and in-patient.

MCYS Program Guidelines and Requirements #01 state that “intensive treatment services include a suite of services”¹ (including intensive community-based/day treatment and intensive in-home services), which operate within a continuum of needs-based services and supports.

Currently, residential treatment is the majority of funded intensive service in the province, leaving few resources for providing intensive treatment outside of 24/7 out-of-home care. Admission to hospital or a CYMH residential treatment setting are frequently the only options available to children and youth experiencing severe mental health problems. Even then, many residential treatment settings don’t have the intensity of services to meet the needs of these children and youth.

Building out the suite of intensive treatment services will ensure 24/7 out-of-home settings are only one strategy to be drawn upon as part of an overall, individualized treatment plan. This paradigm shift establishes 24/7 out-of-home treatment as a service for those children and youth who truly need it, for the time period it is needed, with more effective and appropriately timed transitions to community settings.

Innovative intensive treatment programs, that are available only in a few areas of the province, are showing strong early outcomes:

- In-home treatment: Mental health professionals support the child and family within the family setting; and
- Expanded day treatment programs: Children and youth visit a treatment centre where they attend school and mental health professionals provide treatment and care throughout the day. The family is reunited through the evening hours and overnight. Mental health professionals will work with the family simultaneously to build capacity or address other issues.

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**Intensive Services Are At-Risk**

The government will be introducing a new funding allocation model for the sector over the next few years. We understand the model will not be accompanied by new funding. Lead agencies will soon take over funding allocation responsibility for a system where there are long wait times, significant service gaps, insufficient culturally specific services for Indigenous and other diverse communities, and chronic under-funding.

Residential treatment and other intensive programs are expensive and use a heavy proportion of a local budget that must serve children with a wide range of needs. Some lead agencies are questioning how they can continue to provide this service, particularly given the large existing financial deficits in residential treatment. At the same time, healthcare system reform has identified that these intensive treatment services are important to control hospital costs. In-patient hospitalization costs an average of $2360\(^2\) per day compared to an estimate of the most intensive 24/7 treatment at $800\(^3\) per day. The economic argument\(^4\) for increasing rather than decreasing investment in intensive treatment is clear; however, there is a significant risk that intensive treatment in community settings will decline in the near-term.

**Supporting Child, Youth and Family-Centred Systems of Care**

Research is clear that outcomes for children and youth are better when their family/caregivers are part of the treatment and recovery process. Our definition of family must include a broad range of people – parents, kith, kin, adoptive families or paid caregivers – depending on each child’s individual life context. Historically, family involvement in residential treatment has been weak, “an orientation strongly reinforced by the prevailing mindset across the other child serving systems and training institutions – that parents were the cause of the child’s problems.” “Residential became…a placement, in which the staff individually and collectively took the place of parents in the day-to-day life of the child. The understanding and empathy offered the children was not consistently afforded to the parents.”\(^5\)

CMHO members, over the past decade, have shifted their focus to treating the child in the context of the family and community and are changing to embrace families in a true parent-professional partnership. Children’s mental health providers work with sector partners (e.g., education, child welfare, youth justice, supportive housing, health and the hospital sectors) to transition children and youth back to their families and communities and in the case where families cannot provide care, to independent living or a new home setting.

As part of this treatment partnership, family/caregiver capacity building is essential so treatment gains are not eroded or lost during transitions back to the community. Improved capacity amongst family/caregivers can enable children and youth to either forego or exit 24/7 out-of-home care earlier. In addition, aftercare supports to children and youth leaving intensive treatment must be available as they will continue to have significant needs, and families must be actively involved in planning and/or receiving these services.

CMHO members, new lead agencies and service delivery agencies alike, recommend that an integrated provincial plan for intensive treatment, including 24/7 out-of-home care, is fundamental to providing the services that children and

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\(^4\) Children’s Mental Health Ontario (2016). Improving Mental Health Outcomes for Ontario’s Children and Youth. 2016 Pre-Budget Submission.

youth with severe mental health challenges need. This work needs to begin immediately and must consider the specialized needs of Indigenous, diverse and marginalized communities.

A provincial lens is essential to ensure: consistency of access and standards; alignment with other MCYS, Ministry of Health and Long-Term Care (MOHLTC) and Ministry of Education (MOE) system reforms; and to support regional access to the most intensive, specialized programs. We also believe in the importance of charging lead agencies to develop the plan and allowing residential treatment providers the flexibility to reallocate funds within the suite of intensive services.

The integrated provincial plan must be developed in collaboration with service providers, children, youth and families, and contain the following elements, developed in order.

**A. Define the Needs of Children and Youth Experiencing Severe Mental Health Problems**

1. Start with the needs of children, youth and families, experiencing severe mental health problems.
   - Undertake a provincial needs assessment and planning process supported by MCYS (including Child Welfare and Youth Justice), MOHLTC, and MOE; and sponsored by CMHO and the Centre of Excellence in Child and Youth Mental Health. The needs assessment should clearly define which children, youth and
families need intensive mental health services; what their needs are; and when they need 24/7 out-of-home care (community or hospital).

2. Embed participation of Indigenous, Francophone, Black, LGBTQ and diverse communities in the needs assessment process and as treatment models and interventions are developed.
   
   - Mental health, mental illness and treatment have been defined through the norms and experiences of the dominant culture(s) and often do not adequately reflect the experiences and needs of Indigenous, Francophone, Black, LGBTQ and diverse communities. This has reduced the relevance, accessibility and effectiveness of treatment for these communities. Addressing this gap is essential to improving outcomes for children and youth from Indigenous and diverse communities.

B. Define Treatment to Deliver Identified Outcomes

1. Work in partnership with CMHO members to define treatment outcomes emphasizing: responsive, individualized, evidence-informed, consistent and structured programs to support the neurobiological, emotional, social and developmental needs of children and youth experiencing severe mental health problems.
   
   - CYMH intensive treatment services work with the most vulnerable and severely ill children and youth. Given the histories, experiences and behaviours of these children and youth, when services are not appropriately resourced to respond with effective clinical interventions, they can become overly focused on behavior management approaches as identified in the Panel report.

2. Match treatment models and interventions to deliver agreed upon outcomes.
   
   - Include a range of intensive models and tiers of 24/7 out-of-home treatment so that child, youth and family needs are matched to the right treatment intensities and modalities. Treatment should be based on the best evidence available and upon promising practices; and
   
   - Develop capacity in families to support and reinforce treatment programs.

3. Wrap the adult mental health system around the CYMH system and make mental health supports for caregivers easily accessible.
   
   - Compromised mental health amongst families and caregivers has an enormous impact on the treatment and recovery of children and youth with mental health problems. It is essential the mental health needs of families/caregivers be met as part of effective treatment planning for children and youth. This will help avoid 24/7 out-of-home placements whenever possible and ensure effective transitions back to the community when 24/7 out-of-home treatment is required.

4. Develop a workforce strategy to ensure that the appropriate mental health professionals are delivering treatment.
   
   - In intensive treatment programs, inter-professional teams are required including social work, child and youth workers, psychiatry, psychology, nursing, occupational therapy, physical therapy, etc.; and
   
   - Child and youth worker education programs must be updated to include stronger mental health curriculum given the central role CYWs often play in intensive treatment settings and 24/7 out-of-home care.

5. The data architecture to measure the effectiveness of the treatment programs must be built into the planning stage of the provincial system and supported in the workforce strategy.
C. Resource Treatment to Drive Outcomes

1. Resource the system based on newly defined treatment standards and identified child, youth and family needs.
2. The new funding model must include and reflect the level of clinical treatment and care required to achieve positive outcomes for children and youth experiencing severe mental health problems. A funding model will be easier to achieve once needs have been clearly identified and treatment and outcomes have been clearly defined.

D. Build Accountability Infrastructure

1. Develop accountability mechanisms based on defined treatment and service standards.
   - Accountability frameworks and licensing should be anchored in defined treatment and service standards and these mechanisms should follow work to implement standards rather than precede it; and
   - As lead agencies move into year three of community planning, the development of province-wide standards and indicators provide an important anchor to ensure consistency in approach across the province even while supporting the need for locally responsive and defined service offerings.

E. Plan for Continuous Quality Improvement

1. Define quality goals and create a quality plan to achieve these goals, because improving quality is the single biggest enabler of better outcomes for children and youth.
   - Building an effective, high quality residential treatment system will require a long-term strategy with a multi-dimensional approach so that all elements of quality improvement (e.g., evaluation, performance management, capacity building, accountability, funding/incentives, and engagement of children, youth and families) work in concert. See “The Dimensions of Quality Improvement” in Appendix D. We urge MCYS to work collaboratively with CMHO, our members and all stakeholders to make this plan a reality. Support for a Health Quality Ontario Initiative in the CYMH sector is our first “Priority Investment” identified below.
2. Embed child, youth and family voice within all system improvement initiatives.
   - We are committed to ensuring the voice of children, youth and families are meaningfully heard at all levels of the system and throughout the government reform of residential treatment in Ontario – but we know there is much work to do in order to get there;
   - We encourage the government to partner with the sector to develop the most effective ways to build capacity for child, youth and family engagement across all aspects of the treatment, quality improvement and system design process. Youth and family participation should include, but not be limited to the establishment of an Advisory Council; and
   - Particular attention must be placed on engaging with communities who may not typically be included in system-wide conversations, including but not limited to Indigenous communities.
3. Build and reinforce linkages across sectors.
   - Address critical gaps in culturally specific services for Indigenous and diverse communities, as well as gaps in other sectors such as education, child welfare, youth justice, supportive housing health and hospital sectors; and
Address the critical areas of transition between the education, child welfare, youth justice, supportive housing health and hospital sectors.

Call to Action: Make Priority Investments While Longer-term Planning is Underway

We urge the government to begin investment in building a strong service system for children and youth with the most intensive needs.

A. Provide targeted stabilization funding to address critical gaps and prevent loss of bed capacity during the transition to a more effective system

1. There is an urgent need to provide agencies with additional funding so that they can meet minimum clinical requirements. Many providers are running deficits because they do not want to drop below basic levels of service, and even in doing so they are not providing the level care required to meet the severe needs of the children and youth they serve. This is a grave concern. In addition, reduction of service capacity will almost certainly result in increased hospital utilization, at a substantially higher cost to the government.

B. Make investments that support the Roadmap for Change

1. Support a Health Quality Ontario Initiative in child and youth mental health.
   - MCYS should invest in the child and youth mental health sector’s participation in E-QIP: Health Quality Ontario, Canadian Mental Health Association (Ontario) and Addictions and Mental Health Ontario initiative called the “Excellence through Quality Improvement Project”. This project is designing a framework for investment in high-quality, person-centred care in the adult mental health and addictions sector. Work has been underway for over a year, so there is an opportunity to leverage key learnings and maximize existing government investments.

2. Invest in data, evaluation and research.
   - Data about population health needs, agency and system performance and child and youth outcomes must be the cornerstone of a well-functioning and high quality system. Research and evaluation must be supported so that promising practices can be assessed, replicated and scaled based upon solid information about what is most effective for meeting the needs of children and youth.

3. Make targeted investments that reinforce the appropriate role for residential treatment (i.e., as a short-term intervention that is part of an overall treatment plan).
   - Invest in innovative new treatment models that are driving strong outcomes for children, youth and families with intensive needs. Promising practices include in-home interventions and expanded day treatment;
   - Build effective and intensive after care within the CYMH system, including interventions targeted to family and caregiver capacity building. This will enable children and youth to exit residential treatment earlier. It will also strengthen and sustain treatment gains so they are not eroded or lost altogether during transitions back to the community. CMHO members have innovative programs that can be leveraged; and
• Support CMHO’s proposal for pilot “step-down” options that bridge hospital and community care. This will reduce pressure on both the residential treatment system and the hospital sector, and benefits children and youth by providing specialized care and a transition period for assessment and treatment planning after acute mental health episodes.

Conclusion:

CMHO members are eager to work with the Ministry of Children and Youth Services as it designs its blueprint for residential services. We look forward to working together to identify and implement strategic, forward-looking solutions to build a family and child/youth-driven system of care for Ontario’s children and youth with severe mental health needs. We urge the government to draw upon the passion and expertise of CMHO members, children, youth and families and other stakeholders to improve quality of treatment, strengthen accountability, improve the continuity of care in the system, build overall system capacity, invest in research, and, ultimately, improve outcomes for some of the most vulnerable children and youth in Ontario.

We caution the government against the implementation of short-term, non-systemic approaches as we believe sustainable, long-term benefits and improved outcomes will not be achieved. Instead, we encourage the government to support:

• Evidence-informed decision-making by funding CMHO to work with its members and partners to embark on the CMHO Roadmap for Change and, as a first step, develop a needs assessment on the prevalence of children and youth, together with their families who require residential treatment; and
• Priority investments in targeted stabilization funding and investments that support the CMHO Roadmap for Change.
Appendices:

APPENDIX A: MEMBER FEEDBACK

1) CMHO’S RESPONSE TO THE PANEL REPORT

Where we align

- **Quality of treatment and care must be improved.** Our member agencies are committed to taking a leadership role to improve service quality. We agree with the Panel that many quality dimensions must be strengthened (e.g., the competencies and training of staff; the voice of youth in their own treatment and care; and the inclusion of and responsiveness to youth with varying identities and contexts); however, we have taken a more comprehensive and systemic approach to quality improvement.

- **Accountability must be strengthened.** We recommend work be done first to clarify what outcomes we expect for children and youth to anchor effective accountability mechanisms at the agency, system and funder level in meaningful quality indicators. We believe one important mechanism to achieve greater accountability lies in a commitment to ensure the voices of children, youth and families are meaningfully heard at all levels of the system.

- **Child, youth and family voice must be heard.** We are committed to ensuring the voice of children, youth, and families are meaningfully heard at all levels of the system and throughout the government’s reform of residential treatment in Ontario. Our members encourage the government to partner with the sector to develop the most effective ways to engage youth and families in the ongoing improvement of residential treatment. The Panel’s recommendation to establish an Advisory Council may be one mechanism of capturing youth and family voice; however, we believe that the government must consult and collaborate with the sector to ensure that the most appropriate approaches are identified and implemented. We further recognize the particular need to engage with specific communities who may not typically be included in system wide conversations, including but not limited to Indigenous communities.

- **Continuity of care must be improved.** This section of the Panel report identifies many areas in which we believe system-building is required, both within the CYMH system and between the CYMH and other key sectors (e.g., education, child welfare, youth justice, supportive housing health and hospital sectors). CMHO’s recent report—Residential Treatment\(^6\)—identifies critical gaps, including a lack of: respite services, intensive child and youth mental health services, aftercare services and family supports, family and caregiver mental health treatment, supportive housing for transitional-aged youth, and culturally specific services for Indigenous communities and diverse and marginalized populations. The role of CYMH residential treatment cannot be defined in isolation of the other services and sectors meeting the needs of children and youth experiencing severe mental health problems (e.g., education, child welfare, youth justice, supportive housing health and hospital sectors).

- **Data must be used to improve services.** It is essential that government work with service providers to determine the appropriate investments in data collection so the system and providers have reliable and effective information about client needs, service utilization, outcomes, and pathways. This way we can address gaps in service, plan based on what is needed, and build better bridges across sectors. Promising

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practices developing indicators for transitions across systems should be reviewed given the importance of improving transitions within and across sectors for children and youth receiving residential treatment and other services. Investments in research on effective residential treatment models and treatment approaches is also needed. CMHO members are highly interested in driving research to improve the quality of care in the CYMH sector. They urge the government to invest in research at the provincial level and the community level, given unique needs across communities.

- **Better training for child and youth workers is required.** We agree with the Panel that more enhanced training and professionalization is appropriate and needed given the role CYWs play in creating a therapeutic milieu. Our members also identified that there is a need for additional training for supervisors to ensure a clear understanding of how to oversee in specific programs—general leadership training is insufficient. Our members also believe that funding for all training must also include the costs for backfilling staff.

**Points of departure from the Panel’s recommendations**

- **Establishing a Quality Inspectorate will improve services.** We believe that focusing on the creation of a Quality Inspectorate will consume resources, attention and focus, but will not realize the improvements children, youth and families need. In the absence of an overall system-wide plan to improve quality, more enforcement of what we’ve got will only confirm the system’s failings and will not create change. CMHO members welcome greater accountability. But the starting point for accountability in a system that has evolved in an unplanned way over decades, is intentional investments into quality infrastructure over the long-term so that residential treatment providers can achieve agreed upon goals. The development of a comprehensive quality plan should guide investments in quality infrastructure.

- **Focusing on individual agency accountability, without a concurrent focus on system level accountability or creating effective systems of care.** We know, and the Panel’s own findings confirm, that the absence of effective systems of care create enormous problems for children, youth and families. The Panel’s ‘Continuity of Care’ section is devoted to these themes. Yet the system levers that would address the root causes of these problems are not addressed by the Panel. Residential treatment must be part of a system of services because we do not want children and youth receiving ongoing care in intensive and intrusive settings any longer than is needed. If children and youth are to have an effective overall treatment experience, residential treatment services must be well connected to other effective and well-functioning CYMH, education, child welfare, youth justice, supportive housing health and hospital supports.

- **No perceptible difference between what happens in treatment and non-treatment settings.** CYMH providers know that mental health residential treatment has important differences from other forms of group care. Nonetheless, we agree it is troublesome that the Panel saw little differentiation when visiting different residential settings. We have made it a priority to do more work with members to better clarify and define the needs of the children and youth who seek our service, as a means to better clarify and define the role of residential treatment. Although defining treatment has been an implicit objective of CMHO’s policy work to date, it has been helpful for the Panel to elevate this issue to greater prominence and for CMHO to make our work in this area explicit.

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- **Prioritizing changes to licencing before clarifying indicators for risk and quality.** We understand that the desire to improve accountability and quality might lead to early action on licencing changes. However, there is a risk to making changes to licensing when the treatment and care delivered in different settings is not sufficiently defined, and when standards of treatment and care have not been established. Furthermore, more enforcement will not generate improved performance if the tools to make changes in service quality are not in place. Our members are eager to work with government to build a quality plan first so that tools are in place to meet more clearly defined expectations. We also think it is important for licensing to be tiered to better reflect the different requirements of different settings.

- **Accreditation as a proxy for quality.** The Panel reported that they were “unable to confirm differences in the quality of services provided based on whether or not an organization is accredited, and noted that organizations with the same level of accreditation appear to have variable capacity to deliver high end services.” While we appreciate that the research is inconclusive, that does not mean there is evidence against accreditation. The Canadian Centre for Accreditation (CCA) has prepared a response (attached as Appendix E) which concludes that there is a lack of quality studies and of system-wide data to sufficiently assess the effectiveness of accreditation. In the meantime, the CCA’s accreditation standards are due for review this year. We will use this as an opportunity to support the CCA in identifying and addressing gaps in the existing standards, as well making standards clearer, more current and consistent, and better aligned with the evolving child and youth mental health structure in Ontario (e.g., with respect to the Community-Based Child and Youth Mental Health Program Guidelines and Requirements #01: Core Services and Key Processes).

**What the Panel missed**

- **Importance of standardized assessment and tiers of service.** Standard assessments, tiers of service and other tools to identify children and youth needs and match them appropriately to service are not discussed in the Panel report. This is a major gap. CMHO recommends that standard assessments be an integral part of the determination for children and youth to receive mental health 24/7 out-of-home treatment. Access to and placement decisions about intensive services should be based on solid evidence to validate the need, ensure effective placements, and define expectations for treatment.

- **The need for a system approach.** Many of the Panel’s most important recommendations (e.g., improving placement decisions, reducing moves and transitions, better matching youth needs to treatment) are directed at discrete areas of the broader system. Our members believe all recommendations should focus on a system level response to ensure the most effective and coordinated care possible as children and youth transition through various parts of the system. We are concerned the Panel’s recommendations will have limited impact because of this lack of emphasis on comprehensive responses to address root causes.

- **The impact of chronic underfunding.** Children’s mental health centres face persistent financial deficits due to funding structures and levels that were set multiple decades ago. These deficits have led to a reduction in the number of residential treatment beds available to children and youth across the province. As recent emergency department data indicates, the prevalence of mental health challenges among children and youth has significantly risen over the last decade, likely as stigma has begun to erode. The combination of shrinking capacity among our agencies and increasing need among children and youth are creating gaps in care. In our sector’s efforts to bridge these gaps without the means to do so, access to timely, effective and quality care is compromised. **And these issues challenge our ability to meet even**
core foundational principles, like health equity, resulting in particularly concerning consequences for diverse populations whose voices are often marginalized.

2) Defining Treatment

CMHO members believe a paradigm shift is needed from the historical view of residential treatment as the last point on a linear continuum. Rather, residential treatment must become one component of a ‘system of care’ that is drawn upon as a 24/7 out-of-home treatment option within an overall treatment plan, instead of the final destination of children and youth with complex mental health problems.

CMHO members work in the space between the residential work in the child welfare and youth justice sector, whose clients often but not always face mental health challenges, and the hospital sector, which focuses on acute health care delivery and is not well-suited for most youth in need of mental health treatment (despite the fact that children and youth often end up there). The profile of the children and youth served are complex and inclusive of: significant past trauma; family histories of hurt, loss and mental illness; interrupted attachment; FASD; ASD; atypical neurobiological development; and restricted opportunities to develop emotionally and socially within families, communities, and schools.

Intensive treatment, including 24/7 out-of-home treatment, must have an integrated clinical and relational framework that views clinical symptoms, diagnosis and treatment in the context of the relational and attachment dynamics and needs of the children, youth and families in treatment and care. The goal of effective treatment settings must be to provide environments and experiences that promote neurological, emotional and social growth with expectations that are realistic and gauged to individual developmental capacity rather than chronological age. This must include concurrent family/caregiver work to build a similar capacity in home, school and community environments. Staff working in CYMH treatment settings, whether at the CYW level or those with more advanced clinical qualifications, must have the skill and experience to advance such integrated practice.

However, the role of CYMH treatment, especially 24/7 out-of-home treatment, has often been unclear and defining treatment has been difficult for the following reasons:

- CYMH residential treatment providers are performing many roles in the system. Sometimes this is due to inconsistent placement processes (no standardized assessment); short-falls in other services/sectors; insufficient family supports/respite care; and an absence of aftercare, supportive housing and other appropriate post residential treatment care options;
- There is little standardization across the province leading to a lack of consistency in how residential services and CYMH treatment are defined or delivered. Related to this, without good data and measurement, we aren’t able to track and define what we do; and
- More research and evaluation of intensive treatment interventions and best practices, including 24/7 out-of-home treatment, is needed.
CMHO members agree that more focused and intentional work to define the role of intensive services, including 24/7 out-of-home treatment, and how to most effectively meet the needs of those children and youth who receive them is needed. We believe this work must start with the needs of children, youth and families and should strive to answer the following questions:

- Which children and youth need intensive services? Are specific diverse communities being excluded from discussion of residential treatment? If so, how do we include them?
- What are the needs of children and youth who need intensive services? How do we define complexity?
- When and why is overnight care required?
- What outcomes do we expect from intensive services and from 24/7 out-of-home treatment in particular?
- What are the most effective treatments and how do we build out an intensive ‘system of care’?

As we build a future system of care for intensive residential treatment in Ontario, we believe that the system must be guided by the following set of common principles:

- Child, youth and family-centered treatment;
- Treatment enables family engagement;
- Treatment follows the child and is tailored to meet individual needs;
- Transitions are as seamless as possible;
- Commitment to continuity of care; and
- Cross-sectoral partners are included as active participants in the system of care.

Effective treatment settings should include:

- Treatment milieu that is structured, strengths-based, and child, youth and family guided;
- Treatment goals that have been developed with children, youth and families, and that include clear plans to achieve the goals as well as agreed upon indicators of progress towards their achievement;
- Unifying and consistent treatment approach(es) (e.g., common language is used so that staff are able to learn and apply consistently, reflects a belief in the value of the therapy and an understanding of the positive change expected, includes specific training, tools and evidence-based assurances);
- Inter-professional staff teams with clear roles and responsibilities;
- Attachment and relational based approaches to treatment and care;
- A focus on positive peer relationships; and
- Trauma informed treatment and care.

24/7 out-of-home mental health treatment is needed when:

- There is significant risk to the child or youth due to symptoms and/or medications;
- To address an acute episode of illness, stabilize symptoms, and offer an assessment of very complex and/or acute needs that require close and prolonged observation;
- Medical, medication, or symptom monitoring is required 24/7 out-of-home; and
- To meet urgent mental health needs within the child, youth and family/caregiving environment.
3) **Licencing**

In its current form, licencing of residential services provides little assurance that the right risks and measures are monitored for compliance. Furthermore, variation from community to community in expectations and approaches mean that there is little common or standard practice from one community and one setting to the next. The lack of differentiation between treatment and care settings further compromises the effectiveness of the licencing system. CMHO in our past Residential Treatment policy paper advocated for a tiered system of licencing that reflected the different realities and risks inherent in different treatment and care settings. Our members continue to see this as an essential component of a redesign of the licencing system.

In the CYMH residential treatment system, unlike other residential services providers, licencing must be tied to an improved understanding of treatment and the clinical quality and risk issues a licencing system should monitor. Work to more clearly define treatment quality and clinical risk factors must be undertaken first to ensure that licencing effectively captures the treatment aspect of CYMH settings. CMHO members believe that accountability frameworks and licencing should be anchored in service standards and these mechanisms should follow work to implement standards rather than precede it.

In the short-term, we recommend:

- Streamlining the current system wherever possible (e.g., don’t review things every year that are fixed and don’t change);
- Linking licencing to risk management (e.g., review providers more frequently if they have higher risk ratings, make licencing reviews bi-annual for providers with a track record of low risk ratings and high compliance); and
- Ensuring that publicly posted licencing results are clear, transparent and meaningfully reflect key quality and risk issues, otherwise, this practice can be confusing to youth, families and caregivers.

Over the long-term, we suggest:

- Creating service and quality standards to anchor the licencing and accountability framework;
- Cross-walking various quality initiatives (e.g., KPIs, risk management register, accreditation, licencing, quality standards development, PGRs) to better understand the most effective function and role of each. Clarifying this will ensure that each initiative is measuring and monitoring the right things and will reduce areas of potential overlap or misalignment;
- Ensuring the relevancy of what is licenced so that licencing contributes positively to overall quality and accountability mechanisms;
- Better aligning licencing with core service framework (e.g., currently, licencing won’t look at infant files even though infants are part of the client group)
- Differentiating licencing requirements for youth justice to reflect different needs;
- Creating tiers of licences that appropriately reflect the variation in settings and requirements;
- Changing and updating the required skill sets for the people performing licencing duties (e.g., in the child care sector, licencing standards are reviewed and enforced by members of the college and therefore have the relevant knowledge and experience); and
• Being clear about what role licencing plays as one part of an overall quality improvement plan (i.e., licencing provides assurance that baseline requirements for delivering a service have been met, but does not on its own address the quality of the services delivered).

4) Youth and Family Voice

CMHO members agree the voice of children, youth and families should both shape the residential treatment system overall and directly impact the treatment that individual youth receive. But we also know this is an aspiration we have not fully achieved that brings with it a number of challenges and questions residential treatment providers continue to grapple with. Through our member meetings and consultations with youth and families, a few primary issues have surfaced: what does “youth and family engagement” really mean, where is it happening consistently and well, and how can we engage with youth and families successfully and in ways that are meaningful to them.

There is a lack of consensus, even among children, youth, and their families, about what ideal and meaningful engagement should look like. This issue is further complicated by the different levels at which engagement can and should happen and the different needs, preferences and capacities of clinicians, youth and families. Youth and family voice should be a fundamental driver of the client experience at all levels: the individual level in terms of treatment and relationships, in shaping programs and services, in organizational development as an agency, and in designing our system.

Making engagement meaningful for youth and families is still an area in which experience and competency is being developed. Although some promising practices exist, many questions remain about what makes engagement worthwhile for youth. How do we engage youth who are not interested in being engaged? How do we balance youth engagement with family engagement in a way that protects the privacy of children and youth, but empowers the family and caregiver to offer the support that is required?

As we move forward, these questions provide us with a starting point. We need to find ways to talk to children, youth, families, and youth engagement experts, and support them in setting the terms for youth engagement across the relevant levels, and work collaboratively in building a plan for implementation across our sector. CMHO, together with its members, has on ongoing focus on developing best practices in youth engagement. In summer 2016, CMHO engaged in a broad consultation with youth at the New Mentality’s annual Disable the Label event as a key step in shaping our efforts in youth engagement going forward.

5) Workforce Strategy

CMHO members agree that staff providing intensive treatment to children and youth must be appropriately qualified to meet the complex needs of severely ill children and youth. In 24/7 out-of-home settings, the level of skill, education and qualifications of staff should be commensurate with the added level of responsibility and risk inherent when children and youth have been removed from their caregiving environments; and the added level of complexity, trauma and distress caused by the separation from families and caregivers and from living in group care with other children and youth experiencing severe mental health problems.

Our support for enhanced training and regulation for child and youth workers (CYWs) is guarded because CMHO
members are concerned that limited/targeted training initiatives may have short-term benefits that are not sustainable and therefore won’t generate improved outcomes or help build an effective system into the future. We believe that a sustained and comprehensive effort to build an effective and well trained work force is essential to achieving improved quality.

But the implementation of such efforts is costly and we are concerned that government investments will be insufficient or short-term in nature. Without infusions of funding to support a system-wide initiative, residential treatment providers that are already operating beyond capacity and generating deficits will only become further destabilized. In 24/7 out-of-home treatment, CYWs support the children and youth with the most difficult issues, work in 24/7 shifts, lack inter-professional support and are paid poorly. For many, as soon as they find better paid opportunities outside of 24/7 out-of-home treatment, they leave and the gains of training leave with them.

Within a longer-term and appropriately resourced workforce strategy, our members agree that the professionalization of CYWs is important in improving quality. CMHO members note that important progress was made when child care workers were professionalized. Our members agree that CYW training is important, however, there is agreement by our members that the specific training recommendations made by the Panel are not the most appropriate ones. Our members unanimously agree that the curriculum at community colleges is focused on behavioral management rather than the underlying mental health challenges that cause the behaviors. As a result, we recommend that the following types of training be introduced:

- Mental Illness 101 – understanding the key biological/social/psychological issues for all of the major areas of illness (anxiety, depression, etc.);
- Cognitive behavioural therapy and dialectical behavioral therapy techniques and application; and
- Principles of creating a therapeutic milieu.

The training should also incorporate various modalities and include competency testing.

Currently new CYWs receive several months of safety training, which is important. These additional training components mentioned above should be paced properly to avoid “overload” and allow for practice within the residence under supervision. Training should be structured over several years to deepen levels of understanding. Funding for staff training must also include the costs for backfilling staff.

Supervisors need to be trained simultaneously in the same subjects in order to maintain the gains of the newly trained staff and appropriate coaching. Many supervisors have been promoted through the system and will gain from more structured training. Supervisors also need training to understand clearly how to oversee in this specific type of program—general leadership training is insufficient. There is a considerable opportunity to provide of coaching and leverage teachable moments that supervisors require training to implement.

6) Cross-Sectoral Coordination

CMHO members, over the past 18 months, have worked to drive sustainable change. A key component of this work is the design of a System Framework (see Appendix B). We have identified that the CYMH system of supports for children and youth with intensive needs have critical missing components including a lack of: respite services, intensive child and youth mental health services, aftercare services and family supports, family and caregiver mental health
treatment, and supportive housing for transitional-aged youth.

In recent months our members have identified that these missing components within the CYMH sector as well as missing components in other sectors are either lengthening the stays of children in residential treatment or contributing to the loss of gains made in treatment. We know that having children and youth stay longer than they need is bad for their overall success and leads to rapidly declining outcomes. But too many kids are sent home or to other settings with no support and treatment gains are lost (as demonstrated in the diagram below). It is important to note that many of the system components required for children and youth to be successful are simply not available.

There are new and innovative cross-sectoral projects that need to be scaled to reach all service areas. For example, for some children and youth the mental health of parent and caregivers is often compromised too, and this may mean children and youth stay longer in 24/7 out-of-home care, or cannot sustain treatment gains when they return home. Look to programs like FACT in Windsor or CMHA Toronto’s Healthy Families program as intensive examples of family support, but consider a range of options including those with lower intensity mental health supports.

It is important to undertake the important cross-sectoral work to clarify roles and expectations for all parts of education, child welfare, youth justice, supportive housing health, hospital and CYMH sectors. Joint decision-making about admission, discharge and placement changes is essential across these sectors and in collaboration with children, youth and families.
**FAMILY AND CHILD/YOUTH-CENTRED SYSTEM OF CARE FRAMEWORK FOR CHILDREN & YOUTH WITH SEVERE MENTAL HEALTH NEEDS**

**CHILDREN, YOUTH & FAMILIES***

**STANDARDIZED MENTAL HEALTH ASSESSMENT**
- Clinical Assessment
- Placement Assessment
  - Eligibility
  - Suitability

**SYSTEM PILLARS**

**YOUTH & FAMILY ENGAGEMENT**

**CONTINUOUS QUALITY IMPROVEMENT**

**OUTCOME MEASUREMENT**

**EVALUATION**

**CASE MANAGEMENT**

**LESS INTENSIVE SERVICES**

**IN-HOME TREATMENT**

**FAMILY SUPPORTS**

**EXPANDED DAY TREATMENT**

**RESPITE**

**OTHER PROGRAMS**

**CRISIS**

**24/7 OUT-OF-HOME (RESIDENTIAL)**
- 1: Care
- 2: Treatment & Care
- 3: Secure
- 4: Secure

**AFTER CARE**
- Transition to less intensive support with family or to supportive housing, independent living etc.

* "Families" include parents, kin, kith, adoptive families, group care etc.—depending on the child’s individual life context.

The following is the Executive Summary of CMHO’s report, titled “Residential Treatment: Working Towards a New System Framework for Children and Youth with Severe Mental Health Needs” released in February 2016

Executive Summary:
Over the past year, Children’s Mental Health Ontario (CMHO) has led an in-depth policy initiative that has brought together service providers, system stakeholders, including associations, children, youth and families to consider solutions to the complex challenges facing the residential treatment sector. We are pleased to release our policy paper, Residential Treatment: Working Towards a System Framework for Children and Youth with Severe Mental Health Needs.

Residential treatment is an out-of-home intervention where children and youth with complex mental health needs receive intensive clinical treatment, careful 24-hour supervision, family therapy, and support for daily activities such as school, recreation and socializing.

Ontario’s residential treatment system has evolved over decades in the absence of a provincial strategy or service plan. This has resulted in a series of challenges, including: residential service providers being forced to close beds due to chronic underfunding; in-patient hospitalization rates rising due to lack of residential treatment programs; children and youth accessing high-cost programs outside the province due to insufficient capacity at home; and Northern children and youth being required to access treatment too far from home. As we build a future system of care for intensive residential treatment in Ontario, we believe that the system must be guided by a set of common principles:

- Child, youth and family-centered treatment
- Treatment enables family engagement
- Treatment follows the child and is tailored to meet individual needs
- Transitions are as seamless as possible
- Commitment to continuity of care
- Cross-sectoral partners are included as active participants in the system of care

In accordance with these principles, the following policy and program elements were identified through CMHO’s work as being critical to the design and function of our future model of care for children, youth and families with highly complex needs:

1. Using standardized mental health assessments to deliver stronger outcomes
2. Providing intensive residential treatment that matches the needs of children and youth
3. Building intensive alternatives to residential treatment
4. Building after-care programs as a key component of intensive programs – residential and non-residential

This report presents timely and solutions-oriented recommendations based on in-depth consultation across many groups of stakeholders. In particular, it examines the need to:

- differentiate services based on the needs of the children, youth and families with a proposed provincial system design framework for residential services;
- scale-up investment in existing community-based residential treatment programs for those with
the most complex mental health issues, to meet the demand for services; and
• spread the development of new, intensive non-residential programs demonstrating strong outcomes through investment and removal of the barriers to re-purposing existing funding.

There is now an opportunity to harness the momentum for change by bringing service providers, partners and stakeholders together to work towards an improved system of care for the children, youth and families who need it most.
Dimensions of Quality Improvement

Illustrative Model*

- Accountability agreements
- Public reporting
- Regulations, compliance and inspection
- Accreditation
- Measuring outcomes
- Clearly defined tiers and client needs
- Defined clinical practice and guidelines
- Capacity building

Children, Youth and Family Experience
- Right staff complement
- Capital reinvestments
- Funding reform
- Funding and incentives
- Top-down performance management

Children, youth and family shaping the system
- Individualized care plans
- Child, youth and family voice embedded in treatment and all agency and system improvement initiatives
- Client satisfaction survey

* Adapted from MOHLTC presentation. Model based on UK Government's Approach to Public Service Reform.
THE ROLE OF ACCREDITATION IN SUPPORTING QUALITY OUTCOMES FOR CHILDREN AND YOUTH

A discussion paper for the CMHO Symposium: Responding to the Residential Services Panel Report

June 29, 2016
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INTRODUCTION

The recent Residential Services Review Panel’s report on residential care for children and youth in Ontario (Because Young People Matter, February 2016) raised questions about the impact of accreditation on the quality of service delivery.

Does accreditation lead to better quality?

How important is accreditation’s contribution to quality improvement and improved client outcomes?

The Review Panel reported finding limited evidence in the literature to answer these questions and that in their own review, they were not able to confirm the differences in the quality of services based on whether an organization was accredited (p. 37).

The Canadian Centre for Accreditation (CCA), a national provider of accreditation for child and youth mental health organizations, child welfare organizations, youth justice providers, and other community-based health and social service organizations, has also reflected on the existing literature regarding the role of accreditation in supporting quality outcomes.

Below, CCA shares some of its findings, and posits that more peer-reviewed research is needed, especially in contexts relevant to children and youth services in Ontario.

WHAT WE KNOW AND DON’T KNOW

The Review Panel noted that research literature related to accreditation and its role in quality improvement shows mixed results. (p. 37). For CCA, this points to gaps in the research that are leaving important questions unanswered. Among the gaps:

- There is a lack of quality studies and of system-wide data to sufficiently assess the effectiveness of accreditation.
- The studies and papers published to date are primarily qualitative or descriptive.
- In most cases, studies have neither reflected Ontario nor examined accreditation in service sectors outside of health care.
What CCA has learned from its participating organizations

While the current research literature may prove somewhat inconclusive, CCA’s own data is shedding some light as to the impact of accreditation on service quality. CCA’s internal data and findings from evaluations conducted with organizations that have participated in CCA accreditation support the value proposition.

Participating organizations report that undertaking an accreditation review has helped them to affirm their commitment to quality improvement and to take concrete steps to improve their operations and services. The accreditation cycle helps to instill a discipline when it comes to the planning and timing of an organization’s quality improvement initiatives. The accreditation standards themselves provide quality-focused goal posts. With standards that are regularly reviewed and updated to align with leading practices and emerging trends, there is a built-in and continuous quality improvement arc.

These are some of the benefits reported most frequently by Ontario-based organizations that have completed an accreditation with CCA. They report that the accreditation process:

- Enhances their culture of learning, quality improvement and accountability
- Supports learning about leading practices
- Strengthens their systems and processes in order to improve organizational effectiveness
- Motivates board and staff to work towards common goals
- Demonstrates to the community, people served and funders the organization’s commitment to ongoing quality improvement, risk management and accountability
- Provides third-party recognition for achievements of their organization

Qualitative feedback gathered through surveys of CCA-accredited organizations and through feedback provided by key leaders of child and youth mental health organizations, points to improved capacity over the years of participating in accreditation. Since the first child and youth mental health accreditation by CMHO in 1988, sector leaders have observed continually increasing capacity when it comes to quality improvement processes, and in articulating and evaluating client outcomes.

What peer-reviewed studies on accreditation point to so far

A scan of the research demonstrates the sparseness of available peer-reviewed data, and its limited transferability to child and youth mental health and residential service provision in Ontario.

The three papers referenced in the Panel’s report were less than conclusive. Specifically:

- A study comparing treatment outcome differences between youth offenders from a rural accredited residential treatment centre and a rural non-accredited centre found that “even though the youth at the accredited facility began treatment with significantly higher risk they were at significantly lower risk after 4-6 months than youth at the non-accredited facility.” However, the authors were cautious about linking this correlation to accreditation, as there may have been other factors at play such as the amount of funding provided. (Coll, Sass, Freeman, Thobro, Hauser, 2013)
- A study analyzing health care professionals’ attitudes towards accreditation, as reported in a number of studies, summarized that, “in general, the attitude of health care professionals towards accreditation ... was supportive,” with the few studies that
found negative attitudes questioning the impact of accreditation on the quality of health care services. (Alkhenizan & Shaw, 2012)

- A comparison of the requirements of accreditation standards in several countries concluded that the standards did not focus on learning-organization qualities as much as other aspects of an organization. (Bell, Robinson & See, 2013)

There is some limited peer-reviewed literature beyond the three papers cited in the Panel’s report, among it:

- A 2012 Cochrane Review (meta-analysis) was attempted on the question “Can third party inspection of whether or not healthcare organizations are fulfilling mandatory standards improve care processes, professional practice and patient recovery?” Only two studies met the rigorous inclusion criteria (randomized controlled trials, clinical controlled trials and controlled before and after studies). One was of the South African hospital accreditation program, which did show improvement on the standards compliance scores of participating hospitals, however only one indicator of hospital quality demonstrated statistically significant improvement. (Flogren, Pomey, Taber & Eccles, 2011)

- In 2012, the Canadian Foundation for Healthcare Improvement published a paper titled A Synthesis of Quality Improvement and Accreditation Mechanisms in Primary Healthcare. The paper concluded that research on the impact of accreditation on patient care was sparse and that additional research was needed to be able to definitively recommend the promotion of accreditation to improve quality care. The report referenced two studies that examined outcomes and found accreditation to improve care (citing specifically a higher attention to quality assurance and more infection control measures, as well as more frequent audits of clinical records, credentialing methods used, providers reviewed and staff trained). In a study pertaining to substance abuse treatment facilities, accreditation was found to be positively associated with the percentage of physical exams and mental health care received by patients. Page 11 of the Synthesis paper concludes: “Studies have suggested that accreditation results in improved teamwork, improved access to care, increased awareness of patient safety, improved practice systems and care processes and in turn improved quality of care.” (Canadian Foundation for Healthcare Improvement, 2012)

- A 2012 Narrative Synthesis of health service accreditation literature identified 122 empirical studies that examined either the processes or impact of accreditation programs. A content analysis was conducted to determine the key themes and sub-themes examined and identify knowledge gaps requiring further research attention. It concluded that “the literature is limited in terms of the level of evidence and quality of studies, but highlights potential relationships among accreditation programs, high quality organizational processes and safe clinical care. (Hinchcliffe, Greenfield, Moldovan, Westbrook et al, 2012)

- A complex study of a sample of 19 Australian hospitals found that accreditation performance was significantly positively correlated with higher scores on measures of organizational culture and leadership (around quality improvement), and there was a positive trend between accreditation and clinical performance. Accreditation was unrelated to organizational environment and consumer involvement. (Braithwaite, Greenfield, Westbrook, Pawsey et al, 2010)
KEY THEMES AND NEXT STEPS

What, then, can we take away from the research?

Gaps in research leave important questions unanswered

There are significant gaps in the research that are leaving important questions unanswered.

- There is a lack of quality studies and of system-wide data to sufficiently assess the effectiveness of accreditation.
- Publicly accessible research on accreditation has primarily focused on the health care field.
- In most cases, studies have not reflected Ontario nor examined accreditation in service sectors outside of health care.
- Studies and papers published to date are primarily qualitative or descriptive.
- There is limited transferability to residential service provision in Ontario.

In almost all the studies referenced above, the authors concluded it was not prudent to make strong claims about the impact of health service accreditation on the quality of care. This said, they all found some indications of a promising correlation.

Will ever be possible to “prove” that accreditation was the most significant factor in one organization’s performance on measures of quality of service relative to other drivers? Organizations are not closed systems. They are continuously influenced by multiple internal and external factors, rendering a “cause-and-effect” finding difficult.

Desirable would be a study of a large group of similar service providers—some accredited, some not—in a defined jurisdiction, for example, residential services in Ontario. For this to have value, there would need to be investments in common data and analytics reporting capacity among providers across the province, a consensus on the definitions of “quality service” and “better performance,” and sufficient standards or common measures used across the sample.

CCA supports calls for additional research, and for province-wide investments in data and analytics infrastructure and capacity across the Child Welfare, Child and Youth Mental Health, and Youth Justice service systems in Ontario. Such investments would improve the ability to perform objective and aggregate analysis of a variety of quality indicators across the province and locally within service regions.
Framing accreditation as one driver of quality improvement

It is perhaps best to view accreditation as one part of a broader system that has many different levers pushing organizations to focus on quality improvement. Accreditation is one dimension alongside contributors such as timely access to appropriate training and inservicing of providers, credentialing, care planning, and funder expectations around quality.

Continuing to raising the quality bar

Experience tells us that accreditation has contributed to building a culture of continuous quality improvement among child and youth mental health service providers in Ontario. The challenge before the sector is to continue furthering this trend.

The expert panel’s report has highlighted a number of important questions to ask along the way. The upcoming review of accreditation standards in 2016-2017 affords a timely opportunity for residential service providers, child and youth mental health agencies, Children’s Mental Health Ontario and CCA to join and raise the quality bar together.

About the Canadian Centre for Accreditation

The Canadian Centre for Accreditation (CCA) is a national provider of accreditation for community-based health and social service organizations.

Accreditation provides an external review of an organization’s operations in relation to accepted standards of good practice and risk management. Standards address all aspects of the organization, including governance, management, programs and services. It is also a system to promote learning, improvement, excellence and innovation.

More than 80 child and youth mental health agencies, child welfare organizations and youth justice providers in Ontario participate in CCA’s accreditation program.
REFERENCES


