Designing Justice Services with Youth and Families Who Experience Mental Health and Addictions

Waterloo Wellington
Regional Human Service and Justice Coordinating Committee

December 2014

The purpose of this discussion paper is to frame challenges currently faced by the mental health, addictions, and justice sectors in addressing the needs and enabling the strengths of young people under 18-years-of-age and their families. The need for such a discussion is well known, however the recent suicide of a young gentleman connected with local services highlighted the challenges faced by families in navigating a complex system.

This paper began through conversations with a local family and members of the Regional HSJCC. In this paper, we present the context of developing a provincial strategy; local investment in these sectors; and the experience of a family despite these service developments. Through discussion we hope to explore what worked, what did not, and what can and must be done to improve services as transformation processes unfold. It is important that we honour the stories of people who experience mental illness and addictions challenges, and work to ensure services are better tailored to meet their needs.

Section I:
Brief Introduction and Review of Provincial Context (2005-2015)

Throughout the 1990s and 2000s, it was widely acknowledged and understood that community-based and institutional-based services in mental health and addictions were neither designed nor performing as an effective system – for children, adults or older adults. In part this reality was fueled by the absence of services, and moreover, a combined lack of funding, political (i.e., administrative and legal) and knowledge structures to execute on its development. With the passing of the Local Health SystemIntegration Act (LHSIA, 2006) in Ontario, one of the necessary foundational tools was created to inspire thought and change leadership not only in the health system, but in parallel and necessary systems across the life span to address social determinants of health. Though imperfect in its implementation, the creation of 14 regional networks to plan, fund and integrate services would mark a new important landscape for the province. In part, the effectiveness of the model and local systems leaders limited embrace for change may be improved as suggested by Hy Eliasoph (Healthcare Management Forum, 2014) through further evolution of integration authority. In these early days of provincial policy and legislative change, the experience of Ministry of Children and Youth (created in 2003) was also mixed in its transformation results. As noted recently, the pathway through and out of care for children and youth is "too often based on personal connections, word of mouth, informal networks, or piece-meal information, and too often children, youth and families must rely on their own initiative and advocacy at a time when they are dealing with significant stress" (p.10 – Child and Youth Service Framework 2013).

In this context during July 2009, then Minister of Health, David Caplan with his Advisory Group called several Ministries and people from across the province to 2-day Summit toward the development of a comprehensive strategy on Mental Health and Addictions. Then labelled as the strategy "Every Door is

the Right Door", an initial intent was to integrate services which ensured effective transitions from youth to adult services, and connectivity across a range of sectors, including those delivering resources to improve social determinants of health. Interestingly, the various Ministries involved, including Health, Education, Children and Youth (formerly a division within Ministry of Community and Social Services), Community Safety and Corrections, and Training Colleges and Universities, hold many of the responsibilities and deliver key services of interest here.

10-Year Provincial Strategy – Mental Health and Addictions
In 2011, the *Open Minds, Healthy Minds* Strategy was launched by the province of Ontario, followed closely by the release of our inaugural Mental Health Strategy for Canada (April 2012). The Ontario Strategy privileged investments during the first three years to improve and effect change in children and youth services, totaling $257 million starting in 2011-12.

With the greater emphasis on a whole of government approach, various Ministries and intelligence networks helped focus on key issues, such as challenges for serving transitional-aged youth. In 2011, The Ontario Centre of Excellence for Child and Youth published "*We've got growing up to do: Transitioning youth from child and adolescent mental health services to adult mental health services"*. This is a highly recommended policy paper which provided an extensive review of transition issues, with potential models of intervention such as transition teams, and processes referred to as Transition to Independence that engage youth in individualized planning.

Ministry of Children and Youth Services (MCYS) – Child and Youth Mental Health Service Framework
MCYS Lead Agency Initiative was introduced through *Moving on Mental Health* (November 2012). Announced as a staged process, Lead Agencies would be identified across 34 geographic areas to become responsible for analyzing, planning, funding and monitoring and evaluating the child and youth mental health services in their areas. The first group was recently identified in August 2014, with the final group to be announced in Spring 2015 as part of a second phase.

To support local systems capacity to provide a standard set of core services, a Service Framework was released in September 2013. The draft Service Framework outlines expectations of core services to be provided, with target populations of persons from birth to age 18, and including their parents or caregivers. Particular attention is given to the development of care pathways, which include defined core services with minimum expectations. In the context of implementing a Lead Agency Initiative across the province, the Service Framework will lead to changes in the accountability relationships in the MCYS-funded sector over time. While yet in forming stages, it is clear with intent to strengthen collaboration, and establish service standards and benchmarks resulting in better outcomes for people.

Update on Ministry of Education's Initiatives and Setting the Stage for Years 4+ December 2013
This public presentation from the Ministry highlights numerous investments in the first three years of the Provincial Strategy (see above) and new services recently created across the province, including: Over 770 new mental health workers; Investments through District School Boards, that include: 73 Mental Health Leaders; 145 Nurses; 175 additional workers in schools; 80 new aboriginal mental health and addictions workers; and, 18 Service Collaboratives to support coordinated services across adult, health and justice sectors where some school boards have participated.

The Update from Education concludes with a focuson the future state of the system, described as "Child and youth centered, responsive, flexible, seamless, equitable, evidence-informed and matched to needs". In its look ahead to 2015, the Update reveals 5 key dimensions of what it will look like:

- Parents, children and youth know how to access services, what is available to them and what to expect at each point along transparent service pathways
- Regardless of where they live, families have access to a consistent set of easy to identify supports and services through an identifiable lead agency that is accountable to the government
- Parents, children and youth have confidence in the people and agencies providing services
- Wait times for services are timely, predictable and matched to severity of need
- Parents and funders know whether the services received have made a difference.

Models of Collaboration with Police Services

There is increasing interest and pressure in various communities across Canada to examine and implement a collaborative response model with police services, ensuring ongoing training in mental health and addictions. There are several noteworthy publications released in the past 12 months that indicate further development is required. The first is the June 2014 Mental Health Commission report on Training and Education about mental illness for Police Officers (TEMPO). The second is an independent review on the use of lethal force in the Toronto Police Services commissioned "*Police Encounters with People in Crisis*" conducted by the Honourable Frank Iacobucci, July 2014. The OPP has also published a report OPP-Mental Health Collaboration (December 2013) which reviews a number of Ontario models of collaboration and issues relevant to operations. Each report represents a tremendous body of work and issues raised that are relevant for service providers in direct service, education, and crisis response across urban and rural settings.

Section II:
Local Youth Service Investments in Waterloo Wellington

Since the development of the strategies presented in Section I, there has been significant work undertaken within our local communities to further develop specialized services for youth facing mental health challenges. Since 2011 the following services have been added:

School Based Mental Health Workers: Both Lutherwood and Carizon have developed teams that work with the local school boards to provide service to disengaged youth. These services provide immediate support to individuals, and develop longer-term plans for addressing mental health challenges.

Hospital Mental Health Workers: Lutherwood now has a team that works with local hospitals to provide community-based support for individuals discharged to outpatientpsychiatry. These services are aimed at stabilizing the youth in community settings, and reduce the need for further hospital-based support.

Police & Court Diversion: Both the CMHA and Lutherwood have refined and furthered developed their justice diversion teams. Both organizations have teams that respond with police to mental health calls, to ensure diversion from apprehension under the mental health act, and the criminal justice act. Court-related programs have been strengthened with additional positions, and have develop a strong relationship with the Crown Attorney to ensure diversion where needed. Additional counseling resources have been funded through MCYS to provide services to individuals prior to their 18th birthday, and continuously thereafter until transferred into adult services.

Mental Health and Addiction Nurses: The local Community Care Access Centre has developed a nursing team that provides support to individuals adjusting to new psychiatric and addiction based medicines. This team helps ensure that individuals can stabilize in the community, rather than hospital.

CAMH Service Collaborative: The Centre for Addictions and Mental Health has developed service collaboratives across the province. The initial focus of the Waterloo-Wellington Collaborative was to address transitions experienced by Transitional Aged Youth (TAY). Our collaborative has implemented the Transitioning to Independence Process (TIP), an evidence based model, across the community. This approach ensures that service organizations can be more seamless in providing service to youth and that youth have more ownership over the process.

Connectivity/Situation Tables: The Waterloo Regional Police Service, Guelph Police Service and local social service organizations have come together to collaboratively problem solve complex cases. Connectivity works to address the needs of individuals with acutely evaluated risk factors, to ensure that they receive timely interventions and wrap-around services, which are put in place across sectors.

HERE 24/7: Information, crisis response and coordinated access to services are in first year of implementation in Waterloo-Wellington, and have presented opportunity to consider roles and connections between youth and various adult services.

Suicide Prevention Funding and Development: In 2014, the MCYS provided funding to various regions across the province for suicide prevention efforts to be directed by the community. In Waterloo Region, the Suicide Prevention Council is providing leadership on this initiative. In Wellington-Dufferin, the Suicide Resource Group continues to provide leadership with CMHA WWD recently designating a full-time Coordinator to support its efforts. Locally, the Waterloo Wellington Local Health Integration Network has provided base funding for the development of Skills for Safer Living program for people who experience self harm, often with multiple attempts. This psycho-educational and support process was recently extended in formal partnership between the Self Help Alliance of CMHA with students attending Wilfrid Laurier University and University of Waterloo.

Lutherwood: Over the past year Lutherwood has been working on developing a Relationship Based Strengths Approach (RBSA), which focuses putting relationship development first and taking strengths based approach to service. Lutherwood is implementing the RBSA to ensure engagement of people who are viewed as hard-to-serve clients. As part of this transformation, we are implementing Responsive Leadership - a parallel process to best support staff in implementing RBSA. In addition, Lutherwood has reorganized youth justice programs into one portfolio to increase consistency. In August 2014, Lutherwood was named the Lead Agency for Children's Mental Health in Waterloo Region, to deliver MCYS's intended system transformations.

Section III:
Experience and Issues from Youth and Families

A Local Experience

In 2003, Rob's family became worried about his behaviour. Since local Psychiatry services were unavailable, the family travelled to a Psychiatrist in Toronto. At age 9, Rob was diagnosed with Tourette's syndrome and at age 12, he was diagnosed with Attention Deficit Hyperactivity Disorder.

By age 13, Rob and his parents required more assistance than could be provided by a Psychiatrist located in Toronto. They contacted the intake mechanism to the children's mental health system to arrange an intake that occurred in late October of 2009, with the first appointment for service not being scheduled almost 8 months later in early June 2010. During the first appointment, the consent process created a barrier to entry for service. Rob was ambivalent about receiving service and this weighed heavily in the service's decision to not offer direct treatment to Rob. The services provided at this time included two parenting meetings and two information handouts the family took home.

During the time spent waiting for services, outpatient psychiatry services through the local hospital were declined. During this time, Rob became involved in the justice system, being charged with shoplifting a pop, and creating property damage in the home.

In 2010 (age 15, attending grade 9), Rob and his family continued to access various services including: a local youth shelter (twice); and crisis services. During their initial call to a youth crisis service the family was told "How did you get this number? You have to be signed up and have a "planned" crisis." In addition to these frustrations in accessing services, Rob became further involved in the justice system with additional charges including: property damage in the home, breach of probation, forging a cheque for drugs, and possession of small amounts of marijuana. At this point, the family was unable to manage Rob in the home and had to make the heart-wrenching, and financially burdensome, decision to enroll Rob in boarding school miles away from his home.

In 2011 (age 16, attending grade 10), Rob was further involved with several community based services including: two stays at a youth shelter, intensive in-home services, specialized inpatient psychiatry, and local hospital services. During this process, Rob spent four months on the waitlist for in-home supports, and when entered into services the worker provided two sessions with Rob, approximately ten sessions with the family, and proceeded to close the family as they were unable to gain the required consent. Hospital services provided limited services to Rob and the family due to the continued challenges in gaining consent. Rob's family also tried to have Rob access specialized mental health probation programs, and were declined access.

In 2012 (age 17, attending grade 11), Rob become further involved in the justice system charged with stealing money for drugs, and non-violent criminal harassment. These events resulted in admissions to inpatient psychiatry, where the psychiatrist noted Rob was in a state of severe psychosis at the time of his arrest. At the point of discharge, Rob was incarcerated, released for a period time without supports, and then during a relapse was re-incarcerated for six months in total. During this time, there were two conflicting psychological assessments that kept Rob in detention for an extended period of time.

Throughout 2012 Rob's family tried to gain access to a variety of programming including:probation supports, intensive treatment, and inpatient psychiatry. During this time, the family experienced numerous barriers to service, including: lack of consent, not being able to access service during

incarceration, gate-keeping to services such as specialized regional service, not being able to access services while on deferred custody; and no post-release programming. The experience is summarized by the family as follows: the main point here is that our child with a mental illness, who was also using street drugs, ended up in a jail system for 6 months without treatment for a non-violent crime.

During the remainder of 2012 (after his 18th birthday), Rob continued to become more involved in the justice system with various possession and graffiti charges. These offences resulted in house arrest, after which Rob completed suicide. In addition to the tragic death of their son, the family received follow-up communication from children's mental health to complete a satisfaction survey on their experience.

Based on the family's observations and experience of the mental health and justice systems, and subsequent input from stakeholders, the issues following below require our attention.

Issue #1: Consent

- What is the optimal balance between need for consent, decisions regarding capacity, and the right /need for service for youth under the age of 18?
- How can we ensure optimal contact and engagement to achieve consent?

Issue #2: Relationships

- How do we ensure relationships with clients are consistently operationalized across service providers, particularly in cases where a youth may be ambivalent about engagement with services?
- How do we ensure that these relationships enable creative service options that address complexity?

Issue #3: Advocacy and Information

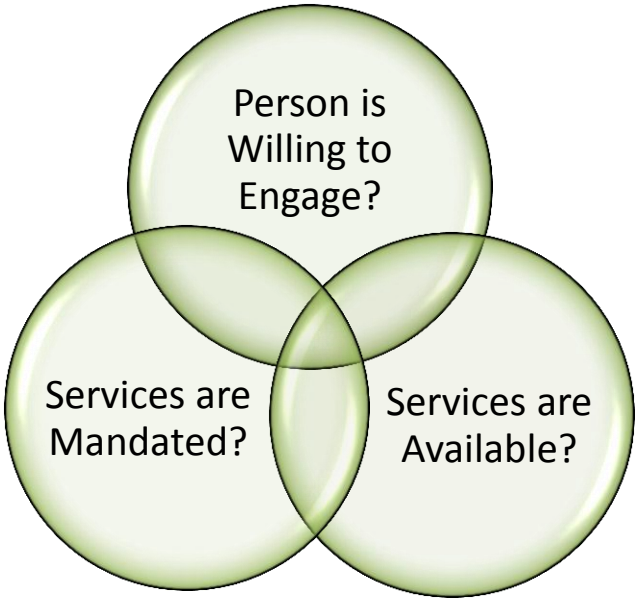
- How do we ensure that parents are empowered, equipped with adequate support and engaged in advocacy for their children with mental health and addiction challenges?
- How do we ensure that service providers are focused on advocacy work for the most complex cases?
- How do we ensure that parents with children involved with probation are empowered to advocate for mental health services, specifically more intensive services?
- How do we ensure that parents, probation, and mental health work collaboratively to find the best possible treatment options for involved youth?
- How do we resolve conflicts between two or more differing psychological assessments?
- Given there are various types of assessments courts may order, how can we ensure that youth with a mentally illness in serious conflict with the law receive comprehensive, multidisciplinary forensic psychiatric assessments that take place in a mental health facility or in community are the appropriate assessments in relation to the courts' needs.
- Can a process be developed to consider effective treatment and support options, while the assessment process unfolds over a period of time?

Issue #4: Commitment to Integrated Service Flow

- How do we ensure youth involved in the justice system are diverted with appropriate access to mental health programs that are concurrent disorder/addiction capable?
- How do we balance the roles of Probation and Mental Health, and ensure that youth are not blocked from service due to complex or co-occurring conditions?
- How do we ensure that health and justice interventions overlap – ensuring consistent treatment from custody to community?

Section IV:
What can be Done Differently? Recommendations for Local Action

Issue #1: Consent. A variety of methods and approaches are used in receiving consent to participate in voluntary services. Frontline service providers may approach the issue too quickly, and raise concerns among participants, particularly youth who are not aspiring to become a "service recipient". This leads to confusion and withdrawal from service. We note both consent (p.30-31) and engagement (pp.36-37) with service participants are highlighted in the MCYS Service Framework. In our current state, youth situations often involve conflict or tension between three inter-related dimensions:



Many people will only receive services where all three elements are present to a sufficient degree, and working together. We need to design mechanisms that can bring sufficient and timely resolution even where only one element is present, and allow youth to participate in services. Especially, where the expressed need includes identified risk and safety issues.

Recommendation: We recommend that services implement a common Consent Management framework that defines a standard approach to garnering consent among youth and families, with the express intent and default position to offer services, including:

a) Create a standard work definition that describes the approach to consent for children's services; ensure the right to support and treatment receives appropriate weighting in the presentation; train staff in the standard work model for consent
b) Consent should not be the first activity undertaken in the course of engagement; ensure there is sufficient time taken to build rapport and understanding of the services being offered; conduct a value stream exercise to refine the core value of voluntary participation.
c) Greater effort and consistency is required to ensure "capacity" for consent, including service refusal, is determined appropriately. A standard practice for assertive outreach should be defined.

Issue #2: Relationships. Among youth service participants a variety of factors influence the potential for beneficial outcomes. Widely recognized as a major contributor is the development of a strong alliance and trusting relationship among helping professionals and youth. A standard best practice should be described and implemented.

Recommendation: We recommend that service standards be developed or refined to define Relationship Building as the foundation of service outcomes, including:

a) Services should operationalize and describe the approach to building a relationship, such as DeGroot – RBSA.
b) Services should examine the role and function of social media tools among youth in terms of relationship building and examining the potential utilization, if any, in service delivery.
c) Develop standards that ensure that service providers in this sector are not the cause of a client's lost hope. In fact, ensure that at all times service providers in this sector are doing everything possible to instill hope.

Issue #3: Advocacy and Information. Families are the core support system and structure for most youth. Where decisions to offer or decline services occur, that do not reflect the best interest of families or their members, an appeal process should be invoked with the authority to review and deliver services. At times, the availability and quality of formal assessments or information provided may be lacking, and contribute to inadequate decisions, carrying forward with negative consequences for youth. The assessment processes require additional clarity, investment to ensure adequate information and rigor, and accountability in the delivery process.

Recommendation: We recommend that information and advocacy supports be provided at the local level for a range of stakeholders, including parents who wish to appeal service decisions and service providers to ensure best practice interventions are designed, including but not limited to the following:

a) A review of potential benefits of service participation, the introduction and offering of service provided to the youth and family, review of contextual information pertaining to risk.
b) Given the complexity of the youth mental health and legal systems and considering the high degree of stress, isolation and stigma parents of youth with mentally illness in conflict with the law experience, ensure information and supports are in place for parents while the youth remains within these systems.
c) Ensure that youth with mentally health challenges in serious conflict with the law receive appropriate assessments by providing the courts, families, service providers and the public with accurate and helpful guides to understand various assessments.

Forensic Assessments:
Fitness assessments are brief assessments solely for the purpose of forming an opinion about the person's fitness to stand trial. Not criminally responsible (NCR) assessments are to determine the state of mind of the person when they committed the act resulting in their charge for the purpose of rendering an opinion as to whether the person understood the nature or consequences of their act and can be held responsible. Neither fitness or NCR assessments include a full psychiatric assessment for the purposes of treatment, neither mandate treatment and neither can form the basis for a pre-sentence report[1].

[1]*Fitness and Not Criminally Responsible (NCR) assessments are the only forms of forensic assessment, and may only be provided by a forensic facility designated by the Minister of Health or a medical practitioner retained by the Ministry of the Attorney General.*

Youth Justice Act Section 34 Assessments:
Section 34 assessments are typically comprehensive multi-disciplinary assessments that can serve a number of purposes including pre-sentence reports and support for diversion from the criminal justice system.

Mental Health Act Assessments:
Mental Health Act psychiatric assessments (e.g., Section 21 and Section 22) are done on either an outpatient or inpatient basis to inform the court and are usually provided by a general hospital or private practitioner.

Therefore, we strongly recommend that given the complexities of understanding these types of assessments and the challenges in organizing them, the various sector leaders and government bodies take well-defined steps to ensure the court and its participants have access to the right assessments, are well informed of their nature, know which assessment will deliver particular results (and the boundaries therein), and where the required assessments can be obtained in a timely fashion. This issue can be resolved; it needs to be addressed now with an appropriate level of urgency and resources for success.

Issue #4: Commitment to Integrated Service Flow.

While strong integration has been proposed and articulated as the strategic direction, service partners from various Ministries must develop and actualize functional agreements that default to an offer of service. A basic premise for such agreement should include a commitment to multiple complex diagnoses such as concurrent (addiction and mental health), dual diagnosis (developmental and mental health), and conditions which may include a variety of physical disabilities whether created through physical trauma (acquired brain injuries) or arising from a genetic basis. There is growing recognition that in spite of undertaking this work to remove gaps between providers, there will also remain significant capacity issues. New investment will be required to ensure the capacity of services to respond.

Recommendation: We recommend that system transformation and new investment proceed with the mandate to ensure robust linkages and integrated service delivery, including, for example:

a) MCYS Lead Agency and First Episode Programs (i.e., with intake potential as young as 14 years-of-age) should have strong partnership and Protocol including Memorandum of Agreement and integrated transition processes, that permit referral of individuals for consideration, and continuous access to support and treatment.
b) Transitions for a small percentage of youth, who are known to require intensive ongoing services from adult system (e.g., Assertive Community Treatment team) should be seamless into funded Adult services by age 19, without any gap in service; the Committee also recommend re-examination of the transition from youth correctional services to adult services with a similar rigor, rather than current lack of information and connectivity.
c) Within Probation services, take a default position that MH counselling will be offered to youth age 12-years- or- older, then require MH Counsellor/Intake staff to determine the best service approach and/or contract to develop in assisting the youth.
d) Utilize criteria for inclusion based on the impact of observable behavior as a greater influence than presence or lack of a formal diagnosis.
e) Robust mechanisms are needed to monitor and ensure new investments strategically enhance the capacity and thereby position service providers to respond effectively to local needs (i.e., standards for appropriate wait times and service initiation are met).

Issue #5: Design Thinking & Empathetic Approaches.

Through our experience here, we re-learned the most important issue: Services in these sectors need to be designed from a customer perspective, and service providers must take an empatheticapproach (e.g., such as articulated by Roger Martin and colleagues at the Rotman School of Management, and advocates such as Patricia Deegan). Without the use of effective human-centred design principles, we unintentionally develop systems that are inaccessible, and complex to navigate. Even where a person is able to access services, theyare often confronted with policy and procedure barriers.

Recommendation: We recommend that service providers andplanners/funders:

a) Explore the use of design thinking, and empathetic approaches to develop the most customer friendly and effective systems.
b) Review and utilize the Ministry of Community and Social Services November 2013 Person-Directed Planning and Facilitation Guide to inform the values and principles of person-centred and directed planning supports.
c) Within mental health and addictions systems, implement a common philosophy where complexity and co-occurring conditions are expected commitment from service providers, as proposed by Ken Minkoff and colleagues in the Comprehensive Continuous Integrated System of Care (see attached) that lead to service provision, rather than exclusion. Chief among these principles ought to be the process of welcoming and inspiring hope.

Section V:
Next Steps in Moving Forward

The following steps/questions in relation to this paper have been undertaken and completed.

1. Review of the draft Discussion Paper with the WW HSJCC Regional Committee:
   - Receive feedback on core/key recommendations
   - Consult/review any related stories or similar themes
   - Consult with WW HSJCC to determine distribution and any targeted audience(s)

2. Discuss potential next steps and feedback on October 7 with the Steering Committee, and initiate contact with Provincial Human Service Justice Committee

3. Finalize and circulate paper to appropriate audience(s): Present to Provincial HSJCC on November 25 2014; Meet with the Committee and gather insight and feedback on revisions, information and appropriate local and provincial responsibilities and actions.

4. Consider final circulation and presentations to target audiences that include: PHSJCC, WWLHIN Program Council on Mental Health and Addictions, MCYS Children and Youth at Risk Portfolio, MCYS Youth and Justice, MCYS Youth Mental Health, Parents for Children's Mental Health, Ontario Medical Association, and additional audiences as identified.

In December 2014 and future 2015 meetings, further follow-up on the local level with the WW HSJCC Regional Committee to:

5. Inspire and develop local action plans as relevant to mandate of Waterloo Wellington HSJCC and affiliated service providers, and support any provincial level improvements.

ATTACHMENT

Minkoff (2012) – ZIA Partners*Comprehensive Continuous Integrated System of Care* (CCISC)
Description and Principles of Complexity Capability

CCISC is both a framework for person- and family-driven system design and a process of getting there in partnership across the whole system.The overall vision is to design the system at every level to be about the needs, hopes, and dreams of thepeople and families that are needing help with all types of co-occurring complex issues—including health,mental health, trauma, substance use, and cognitive conditions, as well as housing, legal, vocational,social and parenting issues.

The core of the vision is that ALL programs and ALL persons delivering care and support become welcoming, person-centered, resiliency-/recovery-oriented, hopeful, strength-based, trauma-informed, culturally fluent, and complexity-capable. In any community, all programs work in partnership to help achieve this vision, so that people with complex needs receive more integrated care within any door. Making the vision a reality is based on implementing a set of evidence-based principles of service, each of which is associated with interventions and strategies that can be used in any setting, with any population, by any person providing care.Making the vision a reality is also based on organizing a system-wide quality improvement partnership, inwhich all types of programs and providers are welcome to come together to move toward the commonvision, and all levels of the system—state and county leaders, agency CEOs, program managers, frontline service and support staff, and people and families who are service recipients—come together in an empowered partnership for change.

The CCISC principles are:

- Complexity is an expectation, not an exception. This expectation must be incorporated in a welcoming manner into everything we do.
- Recovery partnerships or service partnerships are empowered, empathic, hopeful, integrated, and strength-based, working with individuals and families step by step over time, building on their periods of strength and success, to address ALL their issues in order to achieve their vision of a happy, meaningful life.
- All people with co-occurring and complex issues are not the same. Different programs and different systems have responsibility for serving different sub-populations, but all programs are complexity capable.
- Each program provides complexity-capable services to its own population, and helps other programs with their populations.
- All the co-occurring issues are primary, and integrated best-practice interventions for each issue at the same time are needed.
- Progress for any issue involves moving through stages of change; integrated interventions and outcomes should be stage-matched for each issue.
- Active change for each issue involves adequately supported, adequately rewarded skill-based learning, so that individuals and families develop and practice the skills they need to succeed for each issue, with big rounds of applause for each small step of progress.
- There is no one correct program or intervention for individuals or families with complex and co-occurring issues. For each person or family, the correct match is based on these principles.
- In CCISC, the principles inform every program, practice, policy, procedure, and person providing service, with every available dollar and resource, to design the system to be about the people who need us the most.

Notes: Additional tools for clinicians, programs and case presentation accompany this framework.
The WWLHIN Program Council for Mental Health and Addictions adopted these principles in 2014.

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Contact, WW-HSJCC Authors:
Don Roth, MA CHE
Director, Adult Services
Canadian Mental Health Association, Waterloo Wellington Dufferin
E: droth@cmhawwd.ca

Aaron Stauch, MES
Program Manager, Mental Health Services
Lutherwood
E: astauch@lutherwood.ca

Contact, Waterloo Wellington Human Services and Justice Committee:
Chair, Sharon Deally-Grzybowski MSW RSW
E: sgrzybowski@cmhawwd.ca

For further Information on provincial and other Human Services and Justice Committees across Ontario, please see Provincial site: www.hsjcc.on.ca

Human Services and Justice Coordinating Committee Ontario