FAMILY SUPPORT PROVISION: A “MADE IN ONTARIO” MODEL

Final Report

PRESENTED BY:
PARENTS FOR CHILDREN’S MENTAL HEALTH AND KINARK CHILD AND FAMILY SERVICES

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THE MINISTRY OF CHILD AND YOUTH SERVICES

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EXECUTIVE SUMMARY

In 2011, Kinark Child and Family Services and Parents for Children’s Mental Health (PCMH) contracted with the Ministry of Children and Youth Service to develop and pilot an Ontario-specific form of the Family Support Provision Model. The project was divided into two phases, with the first phase involving a literature review and development of the program and the second phase (beginning in January 2012) involving hiring and training of two Family Support Providers and implementation of the program in two sites (Simcoe and York) for a period of 12 months. This phase also involved the collection of evaluation data to inform recommendations for future decision making regarding the program.

The Family Support Provision model was designed to assist and empower families as they interact with the systems that are providing services and supports to their children and youth with mental illness and/or mental health disorders. The objectives of the project were to:

1) To provide an initial implementation of the proposed model;
2) To build the evidence for the “Made in Ontario” Family Support Provision model; and,
3) To develop the knowledge to expand and implement the model across the province.

The key elements of the “Made in Ontario” Family Support Provision model include:

- family-centred/family-focused, driven by cross-sectoral partnerships and family voice;
- informed by policy and evidence; and,
- delivered and supervised by family members with lived experience in the child and youth mental health system

Over the course of implementation of the program in Simcoe and York, 37 families participated. After a hesitant start (some families were unclear as to the role of the Family Support Provider (FSP) and were unsure about participating), Kinark staff and FSPs were able to establish strong relationships with those families who did participate.

The service involved four stages of program:

- Stage 1: Initial meeting with the family and FSP to establish rapport and trust. This is the stage that families began to share their stories with the FSP.
- Stage 2: Mapping of family strengths and the resources available to them (both formal and informal) to help them address their challenges.
- Stage 3: Development of the Family Support Plan to document family goals and tracking of the achievement of those goals.
- Stage 4: Discharge from the FSP program.

Evaluation findings demonstrated that it appears there is some evidence that the FSP program provides positive support to participant families which assists and empowers them to navigate a fairly complex system as well as to enhance their access to other supports for their unique situations. The majority of Kinark staff members reported they were able to focus more on their clinical work because of the Family
Support Provider program and would likely refer clients to this program in the future. They also agreed that the Family Support Provider program is effective for families, children, and youth, however clarity on the role of the Family Support Provider is needed. Clinical outcome effectiveness as demonstrated by pre-post scores on the CANS between participant and comparison families was not able to be established due to small sample sizes.

A number of recommendations were suggested as part of the piloting and evaluation of the FSP program. Priority recommendations are as follows:

1. Further implementation of the Family Support Provision model as a key component to support the government’s commitment to a coordinated, responsive system in order to meet the ministry’s goals of making the system make sense to parents, easier to navigate, and facilitating clearer pathways to care;

2. Allow access to FSP service intake to be flexible in order to begin to accommodate other child serving systems to further support streamlined pathways to care;

3. Provide for centralized leadership/oversight of the FSP program by a family-led organization to promote fidelity to the model, training, credentialing and further refinement of the model.

4. Use of a common, validated assessment tool (eg., CANS) at intake to match service to families;

5. Develop and test an adapted FSP service that serves families on the waitlists;

6. Continue to evaluate the implementation and effectiveness of the program with larger and more diverse client and comparison samples.
The idea of utilizing family experience to support other families navigating the children’s mental health system is an idea generated by Parents for Children's Mental Health (PCMH). Research and observation indicated that trained peer support would create a more holistic and effective approach to service delivery for families. The primary goal of PCMH is to provide support to Ontario families who are dealing with the unique challenges and struggles of raising children and youth with mental illness. Since its establishment in 1994, PCMH has heard consistently about the difficulties faced by families who are dealing with the complexity of services within the child and youth mental health sector as well as challenges navigating other sectors (e.g., education, youth justice, social welfare, health etc). They also struggle with stigma and other emotional issues that hinder their ability to work with systems. These are priority areas for families. To address these and other issues, PCMH established "chapters" across the Province that provide support and informal navigation and education to families. Based on the success of such informal relationships, and the growing recognition of the value of peer-to-peer support in mental health and addiction, PCMH felt that this type of support services should be formalized and should be examined to understand the true impact on outcomes for the children and youth and their families.

Having established relationships with many child and youth mental health agencies across the province, including a strong relationship with Kinark Child and Family Services, PCMH proposed the idea of a more formal family support service. It was thought that this would reflect a new way for agencies and families to work together, a partnership that would be provincial in scope. Through various discussions, it became evident that this type of project would require a phased-in approach.

Phase 1:

PCMH and Kinark contracted with the Ministry of Children and Youth Services to conduct a literature review, best practice study and focus groups with stakeholders to explore the idea of creating a navigation/support service in Ontario. The results of this work led to the government funding a pilot of a “Made in Ontario” model of Family Support Provision (Appendix 1). The phase one document provides a greater level of detail about the history of the concept, the principles and goals of the service and the reason behind the “Made in Ontario” concept.

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The key elements of the “Made in Ontario” Family Support Provision model include:

- family-centred/family-focused, driven by cross-sectoral partnerships and family voice;
- informed by policy and evidence; and,
- delivered and supervised by family members with lived experience in the child and youth mental health system.

Family Support Providers are responsible generally for providing information to families, connecting families to various supports and services in their communities, assisting in navigating systems, advocating for families and helping families to increase their capacity to better support their children/youth.

Phase 2:

On January 24, 2012 Kinark signed an agreement with the Ministry of Children and Youth Services for implementation of Phase 2 of the Family Support Provider project to run until March 31, 2013. This was subsequently extended to May 31, 2013 with the final report due on June 28, 2013. A service agreement was signed between Kinark and PCMH to formalize the partnership and to outline responsibilities of both parties.

Following careful analysis, the Kinark’s program areas of Simcoe County and York Region were selected as locations for the pilot sites (Appendix 2). Both areas allowed for the opportunity to align and build on existing work such as the School-based Mental Health ASSIST Initiative, and Kinark’s program offices are active in the local children’s mental health planning tables.

The Certified Recovery Peer Specialist-Family training curriculum developed by Success 4 Kids & Families in Florida most closely fit the criteria established in Phase 1 and thus was selected as the foundation for the “Made in Ontario FSP Training model” (found in Appendix 1). A positive working partnership with S4K&F was established and continued throughout the FSP pilot implementation.

"My family service provider connected me with other agencies who could assist me in supporting my family. I now receive regular correspondence via email from agencies in my community keeping me on top of opportunities we can participate in - for parental and family supports, social/recreational programs in my community and workshops and information sessions."

Family Participant FSP Pilot
In order to ground the project in a cross-sectoral understanding, a Steering Committee for the FSP Project was established comprised of local and provincial representatives from various child and youth serving sectors and organizations. The membership of the FSP Steering Committee was as follows:

**Family:**
Bev Sirrs (Member of the Phase One team, Family Representative, Durham)
Grace Loucks (Family Representative, Peterborough)

**Mental Health:**
Zaynab Ebrahim (Kinark, York Region, Social Worker; Researcher Phase One of project)
Bernadette Copeland (Kinark, Simcoe County)
Hayley Bennett (Canadian Mental Health Association, Simcoe County)

**Education:**
Kate Diakiw (York Region District School Board, Student Services Coordinator)
Pat Carney (Simcoe Muskoka Catholic District School Board, Chief Psychologist)

**Health:**
Sandy Thurston (Children’s Treatment Network Simcoe-York, Director, Planning, Network Development & Evaluation)
Ligaya Byrch (LHIN staff person with lead for Child and Adolescent Mental Health)
David Jeffery (Community Health Centre Simcoe, Executive Director, Chigamik)

**Child Welfare:**
Ted Soucie (Simcoe County Children’s Aid Society, Senior Service Manager)

**MCYS Youth Justice:**
Lou Ann Micallef (Youth Justice, MCYS, Program Supervisor for York and Simcoe)

**Provincial:**
Phyllis Grant-Parker (Family Representative - Ottawa)
Louise Moreau (School-based Mental Health ASSIST)
Purnima Sundar (CMH – Centre of Excellence)

**Project Team:**
Cathy Dandy (Kinark, Project Manager)
Sarah Cannon (PCMH, Service Lead)
Sandra Cunning (Kinark, Director of Research and Evaluation – until May 2013)
Vicki Mowat (Kinark, Senior Director of Policy and Planning – May 2013 to present)
 Kerrie Van Volkenburg (Kinark, Research)
Chris Simmons-Physick (Kinark, Director York Program)
Kathy Simpson (Kinark, Director Simcoe Program – until April 2012)
Barnabas Walther (Kinark, Director of Simcoe Program – July 2012 to present)
The Steering Committee reviewed and provided input to the project plan, reviewed proposed processes for hiring the FSPs and matching FSPs and families, and assisted with the modifications for the curriculum to create the “Made in Ontario” model of Family Support Provision, including suggested synergies between the curriculum model and local practice.

Smaller sector-specific subgroups met with the Project Manager and the Service Lead to discuss and select the Ontario specific content for education and mental health sections that were built into the FSP Ontario Training Curriculum.

In addition to overseeing the modification of the curriculum to include Ontario content, members of the Steering Committee contributed to the development of an orientation process that allowed the FSPs to become familiar with key personnel in the local organizations as well as local processes that families would encounter on their service journey. In turn, Steering Committee members facilitated local organizations receiving an orientation to the FSP service in order to understand the role of the FSP and its place in the system of support for families.

The Steering Committee met with the FSPs and Kinark staff to regularly review the implementation of the project in York and Simcoe and to understand how the project was affecting families’ experience of the systems. The members played a key role in reviewing the evaluation findings and developing the recommendations contained in this report.
Hirings/Recruitment of Family Support Providers

This model is rooted in a commitment to hire and train family members with lived experience as Family Support Providers. The criteria for the recruitment and hiring of the Family Support Providers was developed in the first phase of the work and supported the hiring and recruitment process in Phase 2:

- Parents/caregivers of children/youth with behavioural, emotional, or mental health disorders
- Parents/caregivers who have first-hand experience with accessing services for a child within the public mental health system in Ontario
- An ability to use personal experiences and knowledge to expand opportunities for family choice and voice
- Able to partner and engage parents and professionals
- A current PCMH member
- Agree to collaborate with the local PCMH chapter
- An ability to participate in the certification course
- An ability to commit to up to one year of support provision
- Successful completion of a security screening process

PCMH worked with Kinark’s Human Resources department to create the FSP job posting (Appendix 3). PCMH and Kinark’s HR continued to work together as a key issue was the need to build PCMH capacity for future leadership possibilities. This included designing a robust hiring process and creating policies that covered areas such as confidentiality, duty to report and safety designed to support effective FSP practice (Appendix 4).

Two individuals were hired in April 2012 (one from each Simcoe and York regions). They both possessed in-depth community knowledge and had established community relationships. Training was provided to them.

"Finally a program where I feel like a partner and not a participant!"

Family Participant – FSP Pilot
TRAINING OF FAMILY SUPPORT PROVIDERS

The FSPs and Project staff attended a five-day training session provided by a professional and family member from the Certified Peer Recovery Specialist - Family Program Training (CPRS) from Florida. The first three days provided the base training for delivering a peer support service and the following two days consisted of “train the trainer” program and working in a smaller group to further discuss the Ontario specific content. This group included the PCMH Service Lead, the Project Manager and the Project Researcher.

The CPRS training was designed to provide learning in the following areas:

- Understanding the basics of the service including collaborating with service providers and families
- FSP Principles including wraparound concept and ethics/confidentiality
- Cultural competency
- Mental health and wellbeing and child development
- The FSP process in working with families
- Establishing and building the relationship with families
- Understanding the education system

As noted, the curriculum was modified by the Project Team and the Steering Committee by adapting the section on mental health and education. Local orientation of the FSPs was organized to further support their understanding of systems such as Child Welfare. Staff was provided with orientation sessions that would support implementation of the model in Simcoe and York.

In addition to the FSP Training, the new FSPs were given Workplace Hazardous Materials Information System (WHIMS) and Child and Adolescent Needs and Strengths (CANS) training as well as a seminar on Ontario privacy law.
As previously stated, the foundation of the FSP service is establishing the peer-to-peer relationship in order to gain insight into the strengths and challenges found in each family and then to support the family. This peer insight is essential to providing the unique support and navigation necessary to effect change. The FSP service is divided into four stages along a continuum. The Project Team developed a check list to ensure that processes were followed and evaluation documents were completed (Appendix 5).

Matching Families to FSP:

The FSP service was made available to clients beginning in June 2012. Front-line Kinark staff offered the Family Support Provider service to clients as they met with them during regular meetings. It was determined early on that the program would not be offered to waitlist clients as they were not yet linked to service or a team of clinicians. To do so would have required modified training for the FSPs which was beyond the scope of the current pilot.

“I really feel that I can open up to you, you get me and what I'm trying to say.”

*Family Participant – FSP Pilot*
LESSON LEARNED: Intake Process and Introduction of FSP Service to Families

Early monitoring of the intake process demonstrated that some families seemed hesitant to accept the service. The Project Team consulted with the social workers who had offered the service to families who declined. They indicated that they felt families were confused about the role and the place of this service within their treatment planning and goals. As a result of this feedback, we changed the process for offering the service to include early, direct contact with the Family Support Provider.

Family Support Providers scheduled time at the program offices and were available to meet with families to introduce themselves and the service as families attended their clinical appointments. This also allowed for a relationship to begin to be established and fostered a stronger connection between the agency staff and the FSPs. The effect of this change in how families were recruited to the service was quickly recognized. Families commented on how meeting the FSP and having a chance to talk to them made it clear how this service differed from clinical work and how helpful this could be for them. Families immediately began the first stage with FSPs and the relationship between the FSP and the workers was established. This meant that the FSP and Kinark worker were able to function as a team from the start when working with families. It was a positive change in how to recruit families and would be the recommended intake method moving forward.

Another Recruitment Option Implemented due to Lessons Learned

In the Simcoe program area, appointments with families were not as readily available and intake seemed to plateau. An additional step of assigning a Kinark worker to make direct calls to families was implemented. The Kinark worker asked families in service if they would like to know more about the FSP service and offered them the opportunity to meet with the FSP. Once permission to provide contact information to the FSP was given, the FSP contacted the family and in many cases set up an appointment to explain the service and assess whether the family would like to become part of the pilot project. This too proved to be beneficial in helping to round out the caseload and bring the FSP service to full capacity. Both FSPs reached the agreed upon case load of 20 families each for the duration of the project.
It has been noted that referrals to the program tended to come from the same individual Kinark staff. When consulting with Kinark workers who sent repeated referrals to the pilot, they stated that they had witnessed benefits of the service and the way in which the FSP supported families and enhanced service provision. They reported feeling comfortable promoting the program to families and encouraging participation. The Project Team concluded that developing a roster of “early adopters” to promote and further orient other Kinark staff to the service would be beneficial.

A few instances occurred where other organizations contacted the project about referring families into the FSP service. Children’s Aid Societies, schools, and families currently waiting for intake inquired about recruitment into the service as they felt it would be beneficial. Staff and families also reported that this program would possibly be beneficial for families when being discharged from direct service to assist with the transition out of direct service, to monitor and build further capacity with families, as well as to ensure that stability is maintained and re-entry into direct service is reduced.

**LESSON LEARNED: Multiple Entry Points to the Program and Multiple Referral sources**

Due to the restrictions of the pilot, referrals were only received through direct referral from Kinark staff. Based on the experience of families in the pilot, intake from all participating agencies could be beneficial.

Also, it was suggested that providing families with immediate access to community resources, setting and maintaining family goals and utilization of both formal and informal supports could prevent relapses into crisis and support smoother transitions from direct service back to community. While this was not assessed in the current pilot, this may be an area that is worth investigating through program expansion.
Stage 1:

Stage one involved an initial meeting with the family, the review of the service including confidentiality and ethics boundaries, completion of documentation and the sharing of the family story. It was the initial and foundational stage upon which the relationship with the family was formed.

The Project Team underestimated the time it took for families to move through stage one. FSPs reported that families spent a great deal of time simply sharing their experience with a peer who had insight and compassion about the journey on which they found themselves. Some families confided in the FSPs that this was the “first time they felt that they had been able to tell their story to someone with a non-clinical, non-judgmental viewpoint, yet someone who understood the way the system ‘worked’”.

Allowing for this extra time during stage one was integral to establishing that unique relationship that would allow the FSP to get to the heart of the challenges facing the family and help them work out the best way to support the whole family. In some instances, FSP’s reported that families shared information with them that they had not felt secure in sharing with their clinicians. This allowed Kinark staff to gain new insight into the most effective way to work with the family in a clinical setting (the information was shared with the clinician only with the permission of the family). The trust that was fostered by the recognition of peer-to-peer understanding gave families an environment in which to feel safe, and a process that allowed them to share sensitive information that included issues of self-shame and stigma in a way that was safe, and productive for both family and child/youth. This ability to elicit new and important information also helped Kinark staff to recognize the unique place the FSP held in working with families, which helped to solidify the FSP’s role in the team.

Stage one also included an assessment of safety risk and clarifying that a safety plan was in place for the family. Again, this was done together with the assigned Kinark staff member.

“I am a social worker and referred a family to the FSP Program. With signed consent I was able to receive information from the FSP that mom was too embarrassed to tell me although she felt comfortable with the FSP and preferred the FSP sharing the information with me. It revised my course of treatment for her son and was impressed the FSP connected mom with a community resource to assist her in dealing with her own challenges.”

Social Worker – Kinark
Stage 2:
The FSPs moved the family into stage two once the family was ready to focus on how to address the challenges they were facing. This was a more formal process of mapping the family’s strengths and available resources as described in the revised FSP Ontario Training Manual. This mapping work was done by conducting focused discussions with all family members and using the eco mapping tool (Appendix 6).

The FSP also used the Caregiver Strain Questionnaire to help determine areas that were causing the most stress or providing the most difficulty in navigation. The FSPs connected with professionals involved with the family at this time. In some cases, this meant that the FSPs were invited to team meetings where they were able to solidify effective working relationships with social workers, clinicians, school personnel, child welfare workers and other key staff. If necessary, the FSP created a team for the family if one did not exist in order to connect professionals and informal supports to each other and work in a coordinated way to support the goals of the family.

“My FSP was able to connect me with resources for my entire family. We were in service for my daughter but I have a son who also has social/communication challenges. His lifelong goal is to become a chef. We never thought it was possible for him to fulfill this dream because of his challenges and finances. She was able to find a program through an agency that offered individuals with challenges support in pursuing his passion for culinary arts. I never would have found this resource on my own. She also encouraged me through identifying my formal and informal supports to assist in financial aid and transportation. It has made a difference to my entire extended family as well. J is able to live with and therefore support his aging grandmother as her home is in close proximity to the program and I was encouraged to ask a family member to pay back a loan to pay for the program. He not only excelled with support, he attended Humber College with the same support 2 then 3 then 4 days a week. He earned a “blue” seal and will be attending Humber College full time in the fall. This never would have happened without assistance from my FSP”.

Family Participant – FSP Pilot
Stage 3:

Stage three involved developing the Family Support Plan to formally document the goals and to track the progress of those goals as the work moved forward. It was important that the goals were achievable and realistic. The FSPs ensured that the family’s strengths were utilized when planning how to achieve the goals and subsequent goals would build on success along the way. The Family Support Plans could include solving transportation issues, dealing with school difficulties, finding respite, helping to support a sibling through the difficult family time, etc. Each family worked with the FSP to choose three or four goals and the FSP and family worked together to build the capacity of family members to meet those goals. This often meant setting smaller goals that would achieve the larger goal. For example, the larger goal might be to have the child return to school but this would mean smaller goals such as the mother becoming more effective in expressing what her child needs, the FSP supporting the mother in a school meeting, finding a mentor for the child and developing an entry plan with the school, the clinician and the family. It was important that goals were manageable for the family so that they were on a solid base to move forward in using their strengths, as well as recognizing working within their current capacity.

The goals were written in the Family Support Plan which became a working document for families and FSPs to follow. This was not a static document and as original goals were met, other goals were sometimes added until the family had increased their skills and established a strong network of resources that would help them. The latter was a key component of FSP work - building connections with formal and informal supports using the mapping tool. The FSP worked with the family to develop problem solving skills, coordinate activities, and coached the family to tell their story effectively to professionals. The FSP also provided ongoing navigation and emotional support to the family in situations that were challenging. The Family Support Plan served as both a guide and a measure of work accomplished.

Stage 4:

The final stage of service involved discharge of the family. The majority of families were involved with the program for a year, met their goals and exited the service with a discharge plan. A few families were discharged from the program if their service with Kinark ended as remaining in service was a criteria for being in the program. Some of these families indicated they would have liked to extend the period of involvement in the FSP Program. In all cases, the FSP was able to assess what goals and supports should be included in the discharge plan in order support the family’s new found ability to cope. All families possessed a clear web of resources and additional capacity to continue to move forward with planning and meeting objectives. This final stage lasted no more than 30 days.

“I’m not afraid to ask for anything now”

*Family Participant – FSP Pilot*
An evaluation of the Family Support Provider program was conducted as part of this pilot initiative. Of particular interest for the evaluation was a qualitative description of how the FSP program was implemented by Kinark and PCMH and also the degree to which the program achieved its intended objectives of enhancing support to families in navigating the CYMH system.

The evaluation was conducted in-house by Kinark research and evaluation unit staff, with support from staff at both pilot sites, as well as staff at the Provincial Centre of Excellence for Child and Youth Mental Health. The evaluation was multi-method and multi-source, meaning both quantitative and qualitative data were collected through various methods to ensure validity of results.

**Data Collection Measures (Appendix 7):**

**Caregiver Strain Questionnaire:** The purpose of the Caregiver Strain Questionnaire is to measure the degree of strain or difficulties families and caregivers experience due to caring for a child with emotional or behaviour needs. This self-report measure was administered to families by the Family Support Provider during the initial meetings with families, then again at the end of service to show the changes in reported stress and strain. Families were asked to rate on a 5-point scale (Not at all, A Little, Somewhat, Quite a Bit, Very Much) the degree to which they were experiencing strain in a number of different emotional/family related areas. A total of 27 families completed the Caregiver Strain Questionnaire at both the start and end of their involvement with a Family Support Provider.

**Family Support Plan:** The Family Support Plan is developed by the Family Support Provider together with the family after their initial meeting. The plan describes the concerns and needs of a family and is used to aid the family in establishing goals to meet these needs. Data from these written plans were used to identify the extent to which families have achieved their intended goals at the end of the program. A total of 39 families completed a family support plan, with 20 in York and 19 in Simcoe.

**Eco Map:** This tool is used by the Family Support Providers and families to help families identify the supports that are available to them, including supports that are actually in place, possible supports they can access, and if they are formal or informal supports. The Eco Map is administered both at the beginning of the FSP program as well as at discharge to identify any changes in the numbers and quality of supports families are able to identify as a result of participating in the program. A total of 37 families completed Eco Maps at the beginning and end of the Family Support Provider service.
Child and Adolescent Needs and Strengths (CANS): The CANS is a standardized measure of need and is one of the regular outcome measures used at Kinark. Families are rated on a 4-point scale (0-no evidence, 1-watch/prevent, 2-action needed, 3—immediate action needed) to assess needs. The domains of the CANS include: Emotional Regulation, Risk Behaviours, Educational Needs, Youth Environmental Strengths, Caregiver/Family Strengths and Needs, and The Family Together. Family Support Providers completed pre-post CANS for each of their families to identify changes in family needs from the start to the end of their involvement with FSP. As a comparison, a sample of 13 families matched on age and Brief Child and Family Phone Interview (BCFPI) scores from the Family Functioning Scales but who did not participate in FSP also had a CANS assessment completed at the start of their service (matched to FSP program start) and again within 30-days of the end of the FSP families programming. According to the Praed Foundation, the CANS is reliable at an item level and validity has been demonstrated through the relationship of the CANS to service use and outcomes.

Knowledge of Services: The Knowledge of Services questionnaire is a paper and pencil self-report measure consisting of 7 items and was used to assess client knowledge of available community services and supports. This was administered at the end of programming.

Caregiver Experience Questionnaire: The Caregiver Experience Questionnaire is a client satisfaction measure that families completed at the end of service regarding their experiences working with the Family Support Provider. To ensure confidentiality (as these measures were administered by the FSP), families sealed their completed feedback forms in an envelope and returned them directly to the research and evaluation department. A total of 23 families completed a Caregiver Experience Questionnaire.

Kinark Staff Experience Questionnaire: Kinark staff who worked with a Family Support Provider were asked to complete an on-line survey about their experiences with the project. In total, 12 Kinark staff members responded to this survey.

Family Support Provider Interviews: Staff from the Research and Evaluation Unit completed 1-hour semi-structured interviews with each of the two Family Support Providers to gather their feedback and experiences regarding the program.

Family Participant Interviews: Interviews with families were conducted using a structured questionnaire with 6-point rating scale. Families were asked to rate their level of agreement on 19 items in order to assess the degree of fidelity and adherence to the Family Support Model by the providers. Almost all (N=32) families participated in these interviews.
Caregiver Strain Questionnaire

The table below provides the results of the comparison for participant families both at the beginning of the program as well as at discharge regarding their self-reported levels of strain or negativity they felt across several areas involving their family environment. The table provides the proportion of families identifying the level of strain or negative emotion as “Quite a bit” or “Very Much” both pre and post program. Analysis indicates that in almost all areas, fewer families reported this degree of strain and negativity at the end of their participation in the program. The two areas where more families identified “Quite a bit” or “Very much” strain and negativity post-program were in their “worry about their family” and in their levels of “resentment”. This could represent the fact that participation in the program enhanced family self-awareness about their issues, whereas prior to program involvement, some families might have minimized the extent of their concern or recognition of the degree of resentment they were actually experiencing.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>PRE (%)</th>
<th>POST (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interruption of personal time</td>
<td>59.2</td>
<td>55.5</td>
</tr>
<tr>
<td>Missing work/neglecting duties</td>
<td>51.8</td>
<td>40.7</td>
</tr>
<tr>
<td>Disruption of family routines</td>
<td>59.2</td>
<td>45.5</td>
</tr>
<tr>
<td>Family member having to do without things</td>
<td>55.5</td>
<td>29.6</td>
</tr>
<tr>
<td>Family member suffering negative mental or physical health</td>
<td>51.8</td>
<td>44.4</td>
</tr>
<tr>
<td>Child getting into trouble with neighbours/school/community/law enforcement</td>
<td>22.2</td>
<td>22.2</td>
</tr>
<tr>
<td>Financial strain for family</td>
<td>55.5</td>
<td>29.6</td>
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<tr>
<td>Less attention paid to other family members</td>
<td>59.2</td>
<td>40.7</td>
</tr>
<tr>
<td>Disruption or upset of relationships within family</td>
<td>51.8</td>
<td>48.1</td>
</tr>
<tr>
<td>Disruption of family social activities</td>
<td>55.5</td>
<td>48.1</td>
</tr>
<tr>
<td>Isolation</td>
<td>62.9</td>
<td>37.0</td>
</tr>
<tr>
<td>Sad or Unhappy</td>
<td>66.6</td>
<td>55.5</td>
</tr>
<tr>
<td>Embarrassed</td>
<td>40.7</td>
<td>22.2</td>
</tr>
<tr>
<td>Relate to child</td>
<td>51.8</td>
<td>55.5</td>
</tr>
<tr>
<td>Angry towards child</td>
<td>33.3</td>
<td>29.6</td>
</tr>
<tr>
<td>Worried about child</td>
<td>81.4</td>
<td>77.7</td>
</tr>
<tr>
<td>Worried about family</td>
<td>48.1</td>
<td>51.8</td>
</tr>
<tr>
<td>Feeling Guilty</td>
<td>44.4</td>
<td>33.3</td>
</tr>
<tr>
<td>Resentful</td>
<td>18.5</td>
<td>22.2</td>
</tr>
<tr>
<td>Tired or strained</td>
<td>70.3</td>
<td>51.8</td>
</tr>
<tr>
<td>General toll on family</td>
<td>74.0</td>
<td>59.2</td>
</tr>
</tbody>
</table>
Family Support Plan

In York, a total of 97 goals were developed with the families. At the end of service, 89 goals were achieved (91.8%). In Simcoe, a total of 76 goals were developed with the families, with 66 goals (86.8%) being achieved by the end of service.

Some of themes of goals are:

- Identifying financial supports and resources
- Improving communication
- Organization
- Identifying and connected to supports and services
- Support completing paperwork
- Building relationships
- Providing emotional support
- Developing strategies
- Advocating for child’s needs

Nearly all families agreed that the Family Support Provider helped them create a plan that was designed to help meet their needs, and all families agreed that the FSPs helped them to set achievable goals. At discharge, these benefits were also realized with caregivers also reporting that things at home (100.0%), as a parent (100.0%) and as a family (91.3%) were improved as compared to when they began the program. This translated into many parents acknowledging they finally had a sense of hope.

“My 8 year old daughter has very aggressive behaviours and runs away quite frequently because of her mental and cognitive issues. I was concerned for her safety in my community. My Family Support Provider connected me with the Mental Health Unit at my local police department and my daughter is now registered with them as a “vulnerable” citizen, we applied and were accepted into the Project Lifesaver Program. Not only will she have a device in the event she goes missing for police to track her whereabouts but my FSP got funding for the locater bracelet and a subsidy for the monthly battery replacement fee. She also provided me with a contact with the local police department in the event I have any challenges in the future. I feel she gave me and my daughter the ability to feel safe and secure in our community”.

Family Participant – FSP Pilot
Pre and post Eco Map results were analyzed for 37 families (20 in York and 17 in Simcoe). The table below provides the average number of supports (actual, possible, formal and informal) in both pilot sites that families thought they had available to them. Results indicate that overall, families were able to identify almost double the number of supports at the end of their participation in the program as compared to when they began. This is substantial, in that it appears families became more aware of other supports and opportunities for assistance once they had been exposed to the FSP and their other service workers at Kinark. Follow up surveys with families also identified that they reported feeling more supported and connected to supports in their community. In fact, many of the family comments referred to two of the best aspects of the Family Support program being:

- their Family Support Provider connecting them to available supports and services in their communities that they did not necessarily know about before; and,
- having support from “someone who has been through the same challenges”.

In addition, Family Support Providers said they felt confident that families increased their capacity and were better able to advocate for themselves by the end of this program. Kinark staff also reported the program as being helpful in assisting families’ access to navigate the complex system of essential mental health services. Overall, the bulk of caregivers reported they were more informed about and connected to programs they could use, were better able to get help from other organizations and agencies, and felt more a part of the community where they live by the time they ended the FSP program.

| Total Mean number of supports identified on Eco Maps at Pre and Post Service (n=37) |
|---------------------------------|----------------|----------------|----------------|----------------|----------------|
|                                 | Actual | Possible | Formal | Informal | Total |
| PRE                             | 7.3    | 1.7      | 5.3    | 3.5      | 8.8   |
| POST                            | 12.8   | 3.0      | 10.3   | 5.4      | 15.5  |
When the results of the Eco Map were broken down by site, the trend remained the same, with families being able to identify more supports available to them at program end. Generally, though, families in York were not able to identify as many overall as compared to Simcoe. An interview with Kinark staff suggested that this was probably due to the fact that there are simply more resources available for families in Simcoe.

| Mean number of supports identified on Eco Maps at Pre and Post service in York Region (n=20) |
|-----------------------------------------------|-----|-------|------|-------|-----|
| Actual | Possible | Formal | Informal | Total |
| PRE | 4.8 | 1.7 | 3.3 | 2.9 | 6.2 |
| POST | 9.4 | 2.3 | 6.8 | 4.8 | 11.6 |

| Mean number of supports identified on Eco Maps at Pre and Post service in Simcoe Region (n=17) |
|-----------------------------------------------|-----|-------|------|-------|-----|
| Actual | Possible | Formal | Informal | Total |
| PRE | 10.2 | 1.6 | 7.6 | 4.2 | 11.8 |
| POST | 16.8 | 3.8 | 14.4 | 6.1 | 20.4 |

**Child and Adolescent Needs and Strengths (CANS)**

The CANS was administered to all but 6 FSP participants at entry and exit from the FSP program. The table below shows the proportion of families being rated in the two most serious rating categories (rating 2 or 3) both at the start and end of FSP participation. Results indicate that the proportion of families remaining in these most severe categories of “requiring immediate action” fell dramatically after their participation in FSP, indicating improvements in the areas of Parenting Skills, Involvement with Care, Problem Solving, Knowledge of Strengths, Communication, Understanding Impact, Organization, Social Resources, Family Functioning and Family Stress. Family Stress decreased most markedly with 88.2% of families scoring a 2 or 3 at entry, and 35.3% scoring in these categories at exit. It should be noted that the possible treatment effects of other services being received by the families could not be disentangled from these data, so results cannot only be attributed to FSP participation.

"My family service provider connected me with other agencies who could assist me in supporting my family. I now receive regular correspondence via email from agencies in my community keeping me on top of opportunities we can participate in - for parental and family supports, social/recreational programs in my community and workshops and information sessions."
Similar results were found regarding “Family Together” items, with improvement in Caregiver Collaboration, Extended Family Relationships, and Family Conflict.
CANS Comparison

The original proposal for the FSP pilot which introduced the notion of a comparison group for evaluation was much larger in scope (four regions with eight FSPs (two in each region)). The intention of employing a comparison group was to establish a more rigorous methodology from which to draw conclusions regarding the outcome effectiveness attributed more specifically to FSP program participation. Inclusion of a comparison group in the original pilot design would have yielded a much larger sample size, and therefore, provided more rigorous and valid data.

In 2011, as a result of the decision to reduce the size of the pilot, the program was limited to two regions with one FSP provider in each within a reduced timeframe (14 months, including program start up and training, resulting in the FSPs only being able to provide direct service for 12 months prior to pilot end). These more constrained timelines and program scope resulted in limited ability to identify appropriate comparison families and also to gather large enough participant and comparison samples to ensure valid statistical comparison. Within this revised pilot, only 13 families could be identified for a comparison group. These were families who would have also been eligible and appropriate for the FSP program (as identified by Kinark staff), but who did not participate in the FSP program.

Thirteen participant families who most closely matched the 13 comparator families on intake BCFPI scores were selected for CANS pre and post comparison. While participant families were administered pre and post CANS by their FSP provider, comparison group CANS were completed through file review by research staff.

Results are presented in the Tables below. Findings suggest that at program entry, FSP families were rated with more urgent needs in most areas compared to the families who were not involved with a Family Support Provider. This provides interesting information regarding the nature and level of crisis that families are experiencing who agree to participate in the FSP program. From a comparison point of view, it introduces a bias into the analysis, in that participant families are qualitatively different from comparator families at the start, despite their BCFPI profiles being similar. While providing informative data regarding what type of families might actually be most attracted to participating in the FSP program (those most in crisis), it does preclude further analysis with the comparison families, including drawing any conclusions regarding the effectiveness of the FSP program.

With that caveat, it is also interesting to note that at program exit, families who were not involved with a Family Support Provider were rated as more urgent in their needs than FSP families in almost all areas.
Similarly, on the Family Together items, FSP families showed a high need in each area at entry to the FSP as compared to the non-FSP participant families, however, at exit, families who were not involved with a Family Support Provider had higher or equal needs in almost all areas.

![Graph showing number of FSP and Non-FSP families with actionable ratings (2 or 3) on Family Together items at Entry (n=13)]

![Graph showing number of FSP and Non-FSP families with actionable ratings (2 or 3) on Family Together items at Exit (n=13)]

Given the limitations to the comparison data methodology, it is recommended that any results be interpreted with caution and no firm conclusions are drawn regarding impact of the program on participant versus non-participant clinical outcomes.
Summary of Evaluation Findings:

Overall, it would appear that there is some evidence that FSP provides positive support to participant families which assists and empowers them to navigate a fairly complex system as well as to enhance their access to other supports for their unique situations. The majority of Kinark staff members reported they were able to focus more on their clinical work because of the Family Support Provider program and would likely refer clients to this program in the future. They also agreed that the Family Support Provider program is effective for families, children, and youth, however clarity on the role of the Family Support Provider is needed.

Although comparison data was not able to yield valid results regarding establishing conclusions around program effectiveness in addressing clinical needs of participating families, the CANS data did provide some interesting information regarding the types of families that might be most interested and amenable in receiving extra support and navigation assistance from an FSP provider.

"My daughter will be attending high school in September. Although I wanted her to continue her education with the same school board she's been with since kindergarten I could not afford the cost of the uniform required for her to attend. With my FSPs encouragement, I connected with the principal of the school to explain my dilemma. He advised me it was not an issue and in fact they had subsidies for families in these circumstances. Not only did we receive a "full uniform" set but my child's file will be flagged and all activity/course fees will be waived and done discreetly as to not cause her any embarrassment or have to miss field trips or school activities because we cannot afford it. I would never have made that call on my own had it not been for my FSPs encouragement. Rather than feeling embarrassed and judged - I felt empowered to advocate for myself and my family"

Family Participant – FSP Pilot
RECOMMENDATIONS

Quantitative and qualitative data gathered as part of the evaluation of the FSP pilot seems to indicate that families in the children’s mental health system who are matched with a trained peer who has made a similar journey is beneficial. The peer provides support navigating the system, helps build family capacity and provides day to day emotional support contributes to reducing families’ stress while enhancing their feelings of increased capacity to cope with the requirements of supporting a child living with mental illness.

These findings are consistent with North American research in the field over the last 15 years.

Review of the literature speaks to the value of the role of family-to-family support providers at client, service and systems level. Family-to-family supports assist in a variety of functions - filling gaps in service delivery, ensuring family engagement in service delivery, and advocacy and systems change work (Adams et. al, 2006; Ireys et al., 1998; Scheer & Gavazzi, 2009; State of Michigan Department of Community Health, 2010; National Federation of Families for Children’s Mental Health, 2010). Emerging data on the impact of this type of service speaks also to increased levels of satisfaction, improved mental health outcomes for children and families, and cross-sector impacts such as improved academic performance, school attendance and system coordination (e.g., Individual Education Plans) (Cheon & Chamberlain, 2005; Conklin et al., 2010; Kutash et al., 200; Munson et al., 2009). (Family Support Provision: A “Made in Ontario” Model, Parents for Children’s Mental Health and Kinark Child and Family Services, October 2011)

Common themes emerging from the majority of families initially seeking service in this project include: they are overwhelmed, that they do not feel heard by professionals, and most indicate that they struggle to manage their lives and make sense of the resources that may be available to them.

The FSP project findings suggest that effectively addressing these issues may require a team effort that includes peer support provided by trained Family Support Providers in addition to mental health clinicians. The engagement of FSPs with families, and on behalf of families, appears to build a bridge between families and providers that creates a climate of trust and partnership, key cornerstones of an effective therapeutic relationship.

In this project we saw evidence of the relationship between the FSP and the family increasing families’ openness to new ways of working that allows the family to move forward.
Priority Recommendations:

1. Further implementation of the Family Support Provision model as a key component to support the government’s commitment to a coordinated, responsive system in order to meet the ministry’s goals of making the system make sense to parents, easier to navigate, and facilitating clearer pathways to care;

2. Allow access to FSP service intake to be flexible in order to begin to accommodate other child serving systems to further support streamlined pathways to care;

3. Provide for centralized leadership/oversight of the FSP program by a family-led organization to promote:
   - Fidelity to the model;
   - Effective training ;
   - Credentialing;
   - Continued development of a model that is still in its early stages of implementation;

4. Use a common, validated assessment tool (eg., CANS) at intake to match service to families;

5. Develop and test an adapted FSP service that serves families on the waitlists;

6. Continue to evaluate the implementation and effectiveness of the program with larger and more diverse client and comparison samples.

Additional Recommendations:

1. Expand FSP service intake to embed the service in other child serving systems;

2. Expand the role of FSPs to support families up to six months after the child is discharged from active service;

3. Follow families for 12 months following discharge from FSP and measure gains at 6 and 12 months;

4. Offer service to all families who determine that they would benefit from it.
We look forward to our continued partnership with the Ministry of Children and Youth Services to make the system easier to navigate and more effective. This type of initiative could be a cornerstone to the transformation of the children’s mental health system and provides an excellent opportunity to harness the experience and energies of those families who have navigated the system and for whom assisting others to do the same is an important next step in their own recovery and development.
Family Support Provision:  
A “Made in Ontario” Model  
(Revised)

Prepared by:  
Parents for Children’s Mental Health  
Kinark Child and Family Services

October 2011

Funded by:  
Ministry of Children and Youth Services
Family Support Provision: Phase 1

Context

The primary goal of Parents for Children's Mental Health (PCMH) is to provide support to Ontario families who are dealing with the unique challenges and struggles of raising children and youth with mental illness. Since its establishment in 1994, PCMH has heard consistently about the difficulties faced by families dealing with the fragmentation of services within the child and youth mental health sector as well as challenges navigating cross-sectoral issues (e.g., education, youth justice, social welfare, health etc). These are priority issues for families.

To address these and other issues, PCMH established "chapters" across the Province that provide support and informal navigation and education to families. Based on the success of such informal relationships, and the growing recognition of the value of peer-to-peer support in mental health and addiction, PCMH felt that this type of support services should be formalized and should be examined to understand the true impact on outcomes for the children and youth and their families.

Having established relationships with many Child and Youth Mental Health Agencies across the Province, including a strong relationship and mentorship with Kinark Child and Family Services, PCMH proposed the idea of a more formal Family Support Program/Service. This would reflect a new way for agencies and families to work together, a way that could exist at a provincial level. Through various discussions, it became evident that the scope of such a project would require a phased approach. Thus, a proposal to examine various models and recommend a model of family support (Phase 1) was submitted to and funded by the Ministry of Child and Youth Services in spring 2010.

The following report is a result of the collaborative work between PCMH, Kinark and the Ministry of Children and Youth Services. It outlines the process and results of a comprehensive review of family support programs and makes a recommendation for a “Made in Ontario” model of Family Support Provision as well as a plan for the initial implementation, evaluation, and mobilization of the model.
**Background**

Parents for Children’s Mental Health (PCMH) and Kinark Child and Family Services (Kinark) are pleased to work with the Ministry of Children and Youth Services (MCYS) to develop a model of Family Support Provision. The model will help families receiving service from MCYS funded agencies engage in and navigate through children’s services.

The development of a Family Support Provision Model aligns with key priorities and recommendations in both provincial and federal policies and frameworks:

- The Mental Health Commission of Canada’s Framework for a Mental Health Strategy for Canada
- A Shared Responsibility: Ontario’s Policy Framework for Child and Youth Mental Health
- Realizing Potential: Our Children, Our Youth, Our Future (Realizing Potential), MCYS’s Strategic Plan 2008-12
- Select Committee on Mental Health and Addictions: Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians

The Family Support Provision Model addresses the priorities and recommendations by:

- Recognizing that children, youth and their families/caregivers need a flexible, broad continuum of services and supports that meet their changing needs through key age, developmental, academic and sector transitions (*A Shared Responsibility*)
- Calling on government and community partners to work together to develop:
  - A child and youth mental health sector that is coordinated, collaborative and integrated at all community and government levels, creating a culture of shared responsibility;
  - A system in which children, youth and their families/caregivers have access to a flexible continuum of timely and appropriate services and supports within their own cultural, environmental and community context (*A Shared Responsibility*)
  - Recognizing that services should be reflect the core principles of child and family-centered care and service (*Realizing Potential*)
- Providing clients and their families access to system navigators who will connect them with the appropriate treatment and community supports (Select Committee, Recommendation #3)

The purpose of the Family Support Provision Model is to enhance service provision, decrease stigma, and improve accountability through a family-centred approach that focuses on meeting the needs of both clients and families (CAMH, 2004). The model must be sufficiently flexible to address geographic and economic differences as well as being applicable across systems (i.e., education, health, and children’s services). Such a model is essential in ensuring that all parents are supported in their understanding of and movement through CMH and related systems.

In an effort to ensure the development of the best possible model(s), the project has been divided into three phases: 1) Phase 1: Planning and Model Development; 2) Phase 2: Initial Rollout/Implementation;
and 3) Phase 3: Full Implementation. The current paper details the work of Phase 1 in which the National Implementation Research Networks (NIRN) approach to the implementation of evidenced-based practices (Fixsen et al., 2005) was employed. This model has driven Kinark’s Clinical Transformation Process.

Phase 1 of the Family Support Provision project (Planning and Model Development) applies NIRN’s first stages, Exploration and Installation. Exploration involves the examination of literature, best practice models in Canada and other jurisdictions and other sources of data to derive models that provide a match between family and community needs, program needs, community resources, and best available evidence. Once the best model(s) is identified the Installation stage begins. Installation involves developing an implementation plan that address NIRN’s 6 main drivers: 1) Recruitment and Selection (e.g., realigning staff, recruitment); 2) Pre-service Training (e.g., courses, accreditation); 3) Coaching and Consultation (e.g., supervision); 4) Staff Performance Evaluation (e.g., feedback); 5) Decision Support Data Systems (e.g., technology, evaluation frameworks); and 6) Facilitative Administrative Supports (e.g., space, HR policies, budgets).

Literature Review

Review Process

- The first step in the project was to develop a literature search process and conduct a comprehensive search and review of both academic, peer-reviewed literature and grey literature (i.e., information that comes from various sources an includes formats such a technical reports, statistical reports, conference proceedings etc.) that focus on family-to-family support programs. The search process included:

- Computer searches of PSYCinfo, Social Service Abstracts and ERIC research databases, with the parameters from earliest to 2011, using the following keywords: Family support models in children’s mental health, parent advocates, parent navigators, family peer-to-peer support, Canadian families and challenges/barriers in children’s mental health, and racism in children’s mental health (See Appendix A)
- Website and Google searches using the similar keywords as above
- Gathering citations from article references
- Email and phone contact with representatives of American and Canadian organizations offering family-to-family peer support programs (e.g., National Federations of Families for Children’s Mental Health, Magellan Health Services, Michigan Department of Community Health, Woodgreen Community Services)
- Presentations and discussions with experts from the major family-to-family organizations at the 21st National Federation of Families for Children’s Mental Health conference
- Programs from widely recognized published reviews and compendiums
Family Support Provision

**History of Family Support**
The past decade has seen a significant increase in the attention to evidence-based practices (EBPs) in the field of children’s mental health (CMH) (Fetterman, et al., 2004). This can be traced to the Cochrane Collaboration in Great Britain that began as an effort to compile and assess the evidence base for practices in health care (Fowler, 2001, cited in Fetterman et al., 2004). The current review is an attempt to reconcile these two streams by connecting the family-to-family support literature to identify the best evidence to inform Family Support Provision Models.

The family support and advocacy movement in children’s mental health has been emerging in the past three decades (Robbins et al., 2008) – a process that has paralleled the expansion of community-based services for families and children (Hoagwood et al., 2009). In Canada, family education and support programs have developed, in part, due to the shortage of family psycho-education programming and the need for support services outside the family context (CAMH, 2009). Many of these programs originated as grassroots initiatives by family members in an effort to offer programs that have focused on giving voice to family needs. Family support and education now includes family-led programs, service provider-led programs, and programs led by family-service partnerships (Dixon et al., 2003). The growing evidence behind the efficacy of family support in children’s services is essential to inform the development of the Family Support Provision Model.

**Family-focused vs. Family-centred Care**
An important step in defining appropriate models is to identify the focus of care. There are two prevalent philosophies for working with families. The first is family-focused philosophy, an approach centred on meeting clients’ needs within the context of the family. The second philosophy, family-centred care, focuses on meeting the needs of both clients and families (CAMH, 2004) where the family is seen as the primary unit of attention. Family-centred care is based on the following principles:

- the recognition that parents are the experts on their child’s needs
- practices that promote partnerships between parents and service providers
- support for the family’s role in decision making about services for their child

(King et al., 2002; Shelton & Stepanek, 1995).

Because of these factors, family-centred care is the philosophy that will serve as the foundation for the proposed Family Support Provision models. Families play a critical role in supporting persons with mental health and/or substance use concerns and in wellness promotion (CAMH, 2004) and, as such, a philosophy that focuses not only on the client but also on family strengths and needs is optimal.

**Family-to-Family Support Defined**
Family support programs range from the provision of information, to support, to parent-to-parent advocacy, allowing families to receive care from others who are in similar circumstances. Many names exist for these programs (e.g., veteran parent, parent-to-parent etc.). Given the focus of the model
development, we will refer hereafter to Family-to-family support programs. Family-to-family support programs are recognized for the unique, personalized support offered to families. These programs often establish a one-to-one match between a parent(s) with a child with “special needs” and a trained parent with professional training. In the programs in the U.S. and Canada, the trained parent holds various titles that include Parent Support Provider, Family Support Provider, Parent Navigator or a Veteran Parent (VP).

The literature (Adams et. al, 2006; Ireys et al., 1998; Scheer & Gavazzi, 2009; State of Michigan Department of Community Health, 2010; National Federation of Families for Children’s Mental Health, 2010) points to different roles carried out by Family Support Providers. These roles include but are not limited to:

- Assisting families in identifying and prioritizing needs
- Providing referrals to community program
- Providing information to aid families in obtaining appropriate services
- Providing emotional support, including before, during and after evaluations or assessments
- Acting as a liaison between families, service providers and services
- Assisting families in developing effective communication strategies
- Assisting families in navigating the children’s service system

The value of family-to-family support models of service provision is clear but is further underscored by the barriers facing families with a child with mental health concerns.

Challenges Accessing Services
Prior to the onset of this project, surveys by both PCMH and Kinark revealed that, despite receiving information when accessing the CMH system, families often struggled to know what to do, what other services were available, who to turn to, and how to deal with other child and youth serving sectors such as education, health and youth justice. The combination of a new, large, and often-fragmented system and their own life situations can leave families isolated and frustrated.

Prevalent Challenges in Ontario
In Ontario, the mental health concerns of children and youth are significant despite improvements in service provision. Although research on the prevalence of mental health disorders in Canadian children and youth is limited, studies suggest that 15 to 21 per cent of children and youth are affected by mental health disorders that cause some significant symptoms or impairment (Waddell & Shepherd, 2002; Shaffer et al., 1996; Offord et al., 1989) - with significantly higher rates for Aboriginal children and youth (Kirby & Keon, 2004). That means in Ontario approximately 467,000 to 654,000 children and youth have at least one diagnosable mental health disorder that causes significant distress and impaired functioning at home, at school, with peers or in the community (Ontario Ministry of Finance, 2006). The potential consequences of mental health problems in children include poor academic achievement, failure to complete high school, substance abuse, conflict with the law, an inability to live independently or hold a
job, health problems and suicide. These issues affect children, youth, their families/caregivers, schools, communities, employers and the province, as a whole.

Clearly, the presence of a serious mental health or addiction problem can have significant implications for all family members. Research has documented the impact of mental illness on families including family/caregiver burden, feelings of grief, loss, guilt, economic burden, social isolation, and stigma (Pejlert, 2001; Saunders, 2003; Maurin & Boyd, 1990). Often when families seek assistance, they also are faced with challenges of the system and factors surrounding the system. These include the following challenges.

**Factors Associated with Access.** A key issue experienced by families is difficulty in both locating and accessing care for their children. This is particularly true for children in low-income neighbourhoods and remote communities. Barriers related to access include:

- Problems communicating with professionals
- Inconsistent information
- Lack of involvement in treatment planning
- Long-term need for services
- Financial strain
- Liaising with other child and youth serving systems
- Transportation
- Challenges locating appropriate support services
- Child care

(Bringewatt et al., 2010; Gonzalez, 2005; Huang et al., 2005; Lefley, 1987; Palmer et al., 2007).

**Factors Associated with Diverse Need.** Aboriginal, First Nations, New Canadian immigrant and refugee families and racialized groups do not readily access conventional mental health services for various reasons including:

- Cultural values surrounding mental health
- Mistrust of mental health professionals
- Fear of disclosure
- Experiences of disempowerment
- Need for culturally and linguistically relevant services
- Community stigma

(Across Boundaries, 2006; Nadeau & Measham, 2002).

Aboriginal and First Nations Canadians face a unique set of mental health challenges. The imposition of European culture and the loss of indigenous culture, lifestyle and self-determination are seen as a major cause of health and social problems in the population (Canadian Institute of Health Research, 2009). In fact, Aboriginal communities experience one of the highest rates of suicide in Canada (Centre for Suicide Prevention, 2003).
Factors Associated with Service Providers Although some literature suggests recent improvements in provider-family relationships and family satisfaction, there is evidence that family needs can go unmet and that families can feel disconnected from the treatment process (Jensen, 2004; Levine & Ligenza, 2002; Winefield & Burnett, 1996). Limited empirical evidence suggests that some of barriers experienced by families are related to the role of mental health professionals and the mental health system (Dixon et al., 2000).

On the other hand, mental health professionals themselves experience challenges that can hinder quality service delivery. Some barriers include:

- Unrealistic expectation about progress
- Lack of involvement/interest from families
- Financial burdens to families
- Client refusal to involve families
- Families lack of knowledge about mental health issues
- Staff time constraints

(Kim & Salvers, 2008; Dixon et al., 2000).

Factors Associated with Systems. Canadian social services agencies have undergone major efforts to adapt their services to meet the needs of diverse client groups in areas of race, ethnicity, religion, sexual orientation, language, and service needs. Despite such efforts, agencies are faced with challenges in delivering appropriate services due to current economic and political circumstances. Over the last few decades, social service agencies faced cutbacks in funding leading to cuts in services offered and greater emphasis on shorter-term intervention strategies (Shera & Bogo, 2001). Family-to-family support programs may indeed assist in getting families to appropriate services. This can include community supports thereby reducing the burden on agencies or fostering community collaborations.

Based on the review of the literature, the challenges experienced by families, practitioners, and the system as a whole highlight the value and role that family-to-family support models can provide in addressing these barriers. A Family Support Provision Model based on family-to-family support can respond to multiple needs and tensions related to navigating the CMH and associated systems.

Assessing Evidence behind Family-to-Family Support Programs

Although emerging for the past 3 decades, family-to-family support has been on the fringe of CMH services (Hoagwood, et al., 2009), receiving far less research attention than other areas (Ireys et al., 2001). According to Hoagwood et al. (2009), in the U.S., family-led support programs have a smaller evidence base as such programs have received significantly less federal research support than other types of programs, forcing research to rely on evaluation designs. Moreover, where evaluation data exists, findings are based on pre-post designs with weak or no comparison groups (Hoagwood et al., 2009).
Evidence that addresses the efficacy of family-to-family support programs focuses primarily on emotional support, the value of shared experience and system navigation (Adams et al., 2006; Hoagwood et al., 2009; Ireys et al., 1998). A review of various models of family-to-family support provision, from the United States, Canada and some international sources highlight the roles of Family Support Providers. While various models exist, the following review highlights model with the best supporting evidence.

**Family-to-Family Support Models and Training Programs: United States**

*The Tapestry Model* (Becker and Kennedy, 2003; Munson et al., 2009)

The Tapestry model was developed in San Diego, California in 2005 to increase access to Wraparound services for families of “colour” with Parent Partners servings as Wraparound facilitators (Bruns et al., 2004). Parent Partners are parents from the community who have personal experience with social services, usually through having a child who has been involved with mental health, special education, and/or juvenile justice systems. Families connected with Parent Partners often experience extreme poverty, high rates of crime and domestic violence, and the highest rate of reported child abuse in the United States (Becker & Kennedy, 2003). Parent Partners contributes to family-driven services within the Wraparound model by providing supports and encouraging parents to partner with professionals in making decisions about the services received by their children (NFFCMH, 2008).

Research examining Parent Partners within Tapestry reveals the unique role of parent supports within the system of care model of service delivery (Munson et al., 2009). The sample included Parent Partners with a range of support experience ranging from over twenty years to six weeks of experience in advocacy work. Parent Partners identified that they:

- Help to translate the content of discussions in meetings with professionals (minimizing miscommunication) and complex paperwork and/or policies.
- Act as navigators for parents and children - providing direction during meetings or direction for work between meetings.
- Help to dispel misperception between parents and professionals
- Assist in improving communication
- Provide education regarding rights and responsibilities
- Work to decrease isolation and stigma
- Facilitate empowerment of parents by connecting families with other parents sharing similar experiences

Parent Partners discussed how their roles were unique to that of professionals. They identified personal experience as central to the uniqueness of their role as well as their abilities and skills to advocate for and connect with families. In contrast, Munson et al., (2009) suggested that the relationships between service provider and families focused on the provision of clinical services. Parent Partners reported that they provided the support component of these services and that their personal experiences facilitated a
stronger connection and understanding of families resulting in increased satisfaction of services. This is not to say that service providers did not offer support to families but that the support provided by Parent Partners was unique, focusing on education and empowerment regarding the system.

In the first year of operation, the Tapestry program served 77 families. Results indicated that most service was related to assistance with information about services, direct mental health services, support for child difficulties at school and advocacy. The average age of the children served was 10, far younger than originally expected. Sixty percent of families were Latino, and the remainder was African American.

After the completion of the first year of services, children and youth scores improved significantly on the Connors Scale (used to assess ADHD and related problems). Scores on the Parenting Stress Inventory revealed a trend toward decreased stress for parents, but the change was not statistically significant. Stress levels may not have shown significant decreases given the complex needs of many of the families involved in the program. In terms of the Wraparound process itself, Parent Partner Wraparound facilitation scored high in terms of preserving family voice, accessing resources, maintaining cultural sensitivity, and providing well-organized, comprehensive plans of care. Results also indicated, however, that Parent Partners had some difficulty when it came to collaborating with professionals and team building.

The Keys for Networking: Targeted Parent Assistance Program (TPA) (Adams et al., 2006)

The TPA model, developed with the support from Dr. Kim Kendziora and Dr. David Osher from the American Institute for Research (AIR) in 1987, is an outcome-oriented, goal-driven process for providing family-to-family support. The program, delivered through the Kansas Parent Information and Resource Centre, focuses on promoting parent engagement. The agency website (http://www.keys.org), reports that TPA addresses parent engagement through various means such as:

- Identifying family-specific interventions and supports
- Offering connections to other families
- Providing information in a variety for formats in user-friendly language
- Structuring opportunities to increase parent voice and choice
- Evaluating the effectiveness of interventions and supports through parent participation, parent reports and child functioning (i.e., education and mental health)

TPA offers family-to-family support by connecting parents to other parents whose children have mental health problems. TPA levels of engagement are based on a ten-level continuum developed from Dr. Barry Kibel’s Outcome Engineering (Kibel, 1996) and Journey Mapping (Kibel, 2000). The continuum describes the movement of parent engagement from seeking information to system advocacy. Using the continuum, each parent’s progress is mapped from seeking help to emerging as a problem-solver to

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becoming a systems change agent. Figure 1 depicts the ten levels of parent engagement, which are grouped into three stages: *Initiation, Solution-Focused, and Expanding Interests* (Adams et al., 2006).

![TPA Continuum: 10 Levels](image)

An evaluation of TPA data from 1656 cases, served over three years (2000-2003), was coded and quantitatively analyzed (Cheon & Chamberlain, 2005). Results indicated that the program supported families by providing strategic interventions and promoting self-advocacy. The results also suggested that TPA assisted with cross-sectoral issues with 30.5% of families presenting with school-related needs. For example, interventions offered included referral information, advocacy, and direct actions with schools such as assistance in obtaining IEPs. Parent involvement along a ten-step growth process, their active/inactive status, and characteristics of level movement were identified. Parents who achieved higher levels on the continuum were more likely to remain active over time than those with lower levels. Approximately one third of clients at the lower end of the engagement continuum maintained contact with TPA for two years versus two thirds of clients at higher levels of engagement.

**Michigan Department of Community Mental Health Parent Support Partners Program** (Conklin et al., 2010).

The Michigan Department of Community Mental Health (MDCMH), with the Association for Children’s Mental Health (ACMH), developed the Parent Support Partners program to assist families with children receiving services from the Mental Health Service Program of Michigan (CMHSP). The MDCMH defined Parent Support Partners as:

- Parents/caregivers of youth with behavioural, emotional, or mental health disorders
- Individuals who have first-hand experience with the public mental health system
- Members of a treatment team included in service, implementation, and transition planning processes
- Having an ability to use personal experiences and knowledge to expand opportunities for family choice and voice
Being able to partner and engage parents and professionals

The Parent Support Provider is responsible for offering family-to-family support to parents of youth with social/emotional difficulties (SED) in the public children’s mental health system by facilitating access to services, assisting families with systems navigation, and teaching families the skills to manage the challenges of raising youth with SED. The role of family-to-family support is significant within children’s services, filling important service gaps and offering equitable employment opportunities.

According to the MDCMH, family-to-family support services delivered within an infrastructure that includes family members in the service delivery system is a key to success. Other critical elements to successful family-to-family support include ongoing training and coaching of support providers, technical assistance, and support to Parent Support Partner themselves. In fact, the MDCMH offers certification opportunities for family members. Certification consists of five days of classroom training and nine months of individual and group coaching for groups of six to eight parent support providers. Professional development opportunities also are offered quarterly.

The MDCMH has recently collaborated with Georgetown University to evaluate outcomes of the Parent Support Partners Program. To date, 100% of family members report being satisfied with the training, coaching, and technical assistance provided by the MDCMH.

*Parent to Parent: Family Training on AD/HD – CHADD* (Children and Adults with Attention-Deficit/Hyperactivity Disorder, 2010)

CHADD is a leading non-profit organization serving individuals with AD/HD and their families in the United States with over 16,000 members in 200 local chapters throughout the U.S. CHADD offers family-to-family support through the Parent-to-Parent (P2P) family training on AD/HD. P2P providers offer educational information and support for individuals and families dealing with and learning to navigate the challenges of AD/HD across the lifespan. Parents with lived experiences as well as access to researchers and practitioners developed the P2P program curriculum across the United States. The P2P course takes approximately 14 hours and is usually offered as a seven-week class (one two-hour class each week) or as an intensive two and a half day certification class. As part of the training package, participants receive extensive materials, including articles, reference materials, handouts, and homework assignments designed to support their work. The curriculum is highly structured, including information on:

- Assessment to Multimodal Treatment
- Managing the Impact(s) of AD/HD on the Family
- Developing Parenting Strategies and Positive Behaviour Interventions
- Educational Rights for Your Child with AD/HD
- Building an Education Team: Bridging the Gap Between Home and School
- Resiliency, Teen Challenges & Future Success

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P2P teachers are CHADD volunteers who have experienced the effects of AD/HD within their families and who have completed the certification process. CHADD identifies the following criteria for becoming a P2P Teacher. The individual must:

- Be a current CHADD member
- Agree to teach at least one course a year in your local community
- Agree to collaborate with the local CHADD chapter
- Either have a family member with AD/HD, have AD/HD yourself, or are willing to teach the class with someone who has AD/HD
- Take the two-and-a-half-day teacher certification class
- Plan to teach the class in the United States

The CHADD program differs from the Tapestry, Keys, and MDCMH programs in that the program is offered to families and individuals as a structured workshop for families whose children have been diagnosed with AD/HD. The CHADD program is similar, however, with respect to supporting families navigate the CMH system, increasing family support and knowledge of community resources and decreasing levels of family stress.

The Parent Connectors Program (supported by the University of South Florida, rtckids.fmhi.usf.edu/)

Unlike other family-to-family support programs that are affiliated to family organizations, the Parent Connectors program is a federally supported research project led by university-based researchers out of the University of South Florida in partnership with family stakeholders. This program was funded as a pilot project with the objective of developing family-to-family support programs that would improve academic performance for children identified as eligible for special education services due to behavioural or emotional needs (Kutash et al., 2006).

Parent Connectors seeks to provide family-to-family support to families with children identified as having “emotional disturbances” (ED) within special education programs in public schools. The goal of the project is to improve outcomes for children and their families through parent participation in an effective, school-based family-to-family support program. The program is a telephone-based support that links experienced parents (i.e., those who have a child who receives services) with parents who have a child identified with ED. Teachers, a family advocacy group, and researchers constructed a program that can be implemented with consistency and evaluated in terms of adherence to the conceptual model.

An early evaluation of the program consisted of parents of children with ED (n =56), “Parent Connectors” (n =3), and the special education teachers (n =14) of the children with ED. The research design was a pre-post design over 9 months, consisting of two cohorts of parent-child dyads randomly assigned to one of two conditions (Teacher Group or Parent Connector Group). In the “Teacher Group” or control condition, parents and students interacted with teachers receiving training and resources to increase parent involvement in the education of their children. In the “Parent Connector Group”, direct
parent support was supplied through telephone calls in addition to the specially trained teacher. Results indicated that:

- School attendance for children was higher in the Parent Connector Group (153.7) compared to the teacher group (137.2) (timeframe is unclear)
- Over the course of the study, family participation in a child’s education increased in Parent Connector Group but decreased in the control group (participation was not defined)
- Using the Vanderbilt Mental Health Services Efficacy Questionnaire, parent self-efficacy increased in the Parent Connector Group but decreased in the control group.

This study is relevant in demonstrating the evidence-base behind family-to-family support programs in school based environments in the areas of improved school attendance, improved family participation in education and improved parent self-efficacy. However, the study lacks the evaluation component used to assess the efficacy of family-to-family support programs. These domains include reduced levels of stress, increased levels of support, and increased knowledge of community resources.

**Family-to-Family Support Models and Training Programs: Canada**

Compared to the U.S., there is relatively little information about the existence of family-to-family support programs in Canada. Family-to-family support programming appears to be relatively new to Canada, particularly within mental health. Where programs exist, there is very little related research or evaluation. The following list contains some of the programs found in Canada:

- The Parent Connector Project was developed by the Vancouver Five Family Places Partnership in 2009 to support recent immigrants and parents who do speaking English.
- The Parent Mentoring Program of Saskatchewan (PMPS) is a long-term prevention, home-visiting service aimed at promoting healthy behaviors and life choices, enhancing social support networks, and improving community resources. The program provides support and practical assistance to expectant parents and parents of young children by matching them with an appropriate volunteer mentor or para-professional and by holding group activities within their communities. The program goals include improving pregnancy outcomes, enhancing healthy childhood development, and improving parental skills and life choices. The program serves rural and urban areas.
- Woodgreen Community Services in Toronto, funded through MCYS, offers family-to-family support training. The program is comprised of eight workers who are all parents of children who have been through the mental health system. The workers are employed part-time with nine to 18 families who have a child that has autism or is developmentally delayed. Families are seen on a bi-weekly basis.
Family Support Provision

Family-to-Family Support Models and Training Programs: International

Like Canada, relatively, little information is available on family-to-family support programs in the international community. What emerged from the current literature search was the Family/Whanau Advisors in New Zealand. The family advisor serves a role similar to that for family-to-family support providers in the U.S. and Canada. According to Like Minds Tarani (2010), the agency that organized the family supporter movement in Taranaki, New Zealand, the Family/Whanau Advisor role is to:

- Provide family-focused direction and leadership for all Mental Health Teams
- Establish the role of family participation in processes and systems
- Promote the best clinical practice within the Mental Health Service.
- Involve families in policy, procedure and process development.
- Conduct regular audits and reviews to ensure family involvement/consultation is recognized and included by mental health staff
- Organize Family/Whanau meetings with staff, if requested
- Meet with Family/Whanau advisors on a one-to-one basis to ensure that families are getting the correct, relevant information

Summary

- Review of the literature speaks to the value of the role of family-to-family support providers at client, service and systems level. Family-to-family supports assist in a variety of functions - filling gaps in service delivery, ensuring family engagement in service delivery, and advocacy and systems change work (Adams et. al, 2006; Ireys et al., 1998; Scheer & Gavazzi, 2009; State of Michigan Department of Community Health, 2010; National Federation of Families for Children’s Mental Health, 2010). Emerging data on the impact of this type of service speaks also to increased levels of satisfaction, improved mental health outcomes for children and families, and cross-sector impacts such as improved academic performance, school attendance and system coordination (e.g., Individual Education Plans) (Cheon & Chamberlain, 2005; Conklin et al., 2010; Kutash et al., 200; Munson et al., 2009). Although emerging, further evidence is required, particularly for Ontario models, models designed to address our geographic and economic differences, and be applicable across our systems (i.e., education, health, and children’s services). This will ensure that all families are supported in their understanding of and movement through CMH and related systems regardless of where they live in Ontario.

Recommendations

An overview of all models (those included in the paper and others) is found in Appendix B. This comparison speaks to the need for the evaluation of a comprehensive model.

- Based on a comparison of models, existing models/programs of parent-to-parent support either do not have sufficient components and/or evidence to support their implementation. Therefore, the Made in Ontario Model is recommended for implementation. It addresses key components that have emerged in the literature and is sufficiently generic to fit to various
contexts (service or geography) as it is based on functions and processes rather than sector-specific content.

- Given the variety of confounding factors that can exist not only across sectors but across like services, a strong test of this single model is recommended (rather than a range of models, as originally specified) so that factors other than the service will not impact outcomes. The ability to determine the overall effectiveness of different models would be extremely difficult. Some of the many factors that would have an impact on outcomes include geography, sector, staff training, organizational culture, and physical resources. These factors would negatively impact the ability to understand the true effectiveness of a model.

- Currently, there is a dearth of strong, comparative evidence regarding parent-to-parent support. There is a significant need for a focused, well-controlled study of a comprehensive model. After sufficient evidence is obtained for one model, the next appropriate step will be to implement that model across sectors and examine how the above factors contribute to or diminish outcomes.
A Proposed “Made In Ontario” Model

Rationale for the Proposed Model
The original plan for Phase 1 of the project was to review the relevant literature on family-to-family support models and select two or three models that would be suitable for trial within an Ontario context. An extensive review of both academic and non-academic literature (See Appendix A) reveals significant emerging evidence for family-to-family support. However, as articulated by Hoagwood et al., (2009), few evaluation studies exist. Of those that are available, the designs are limited (i.e., no comparison groups). A second challenge with the models explored is that many are embedded within an American context and, therefore, are driven and affected by different political, policy and funding issues and systems. A third challenge also exists within the literature. Although many sources describe the roles of providers and discuss the value of family-to-family supports (e.g., Adams et. al, 2006; Ireys et al., 1998; Scheer & Gavazzi, 2009), relatively little research has been directed specifically at the actual impact of “lived experiences” in these models. Finally, reviews of various models revealed several important components, however, no one model adequately addresses the needs of families who are the focus of this project due to limited evidence, restricted types of systems or services in which they were developed or applied and the restricted populations or needs being addressed by the programs.

Given these limitations, we are proposing a “Made in Ontario” Model that will:

- Consist of a composite of various models to address Ontario needs
- Be informed by evidence from our focus group study (see below)
- Reflect Canadian policies (e.g., Mental Health Commission of Canada Framework, 2009)
- Provide the evidence for the value of such a model through a strong, comparison group study

Definitions
A first step in the Family Support Provision project was to develop several definitions and a working lexicon (Appendix D). Key definitions include family and family support provider. Two definitions that are particularly relevant to the model are that of family and support provider. Based on the definition provided by Children’s Mental Health Ontario (2010) a family consists “of two or more people, whether living together or apart, related by blood, marriage, adoption or commitment to care for one another”. In the “Made in Ontario” Model of Family Support Provision, a Family Support Provider is defined as someone who “is currently raising or has raised a child with emotional, behavioural or mental health challenges; has current knowledge of the children’s mental health system, has experience with, and consciousness of the struggle and recognizes the standpoint of the “family”. This is a crucial definition and one that highlights the value-added of family members as support providers: “lived experience”. It is “lived experience” that fundamental differentiates the role of family members from that of mental health professionals. The importance of lived experience is underscored by the Mental Health Commission Canada (2009, p. 17)
“Most importantly, it will be essential to ensure that people with a lived experience of mental health problems and illnesses actively participate in all aspects of the design, implementation and evaluation of a comprehensive, person-center mental health system.”

Or

“Peer support can best be characterized by the fact that people who have like experiences can better related and consequently offer more authentic empathy and validation. It is not uncommon for people with similar lived experiences to offer each other pragmatic advice and suggestions that professionals may not be able to offer them. This kind of support reduces isolation, increases treatment compliance and reinforces treatment-seeking behaviours, which, in turn, helps to combat the stigma surrounding mental health illness. Maintaining a non-clinical vantage point helps peers rebuild their sense of community and trust as these relationships are built around a deep mutual understanding, in contrast to the relationship between clinician and patient (MHCC, 2010, p.6).

**On-line Focus Group Results**

In an effort to inform the development of the model and provide client and service provider voices, two on-line focus groups were conducted with members from PCMH and service providers from Kinark Child and Family Services. Participants were asked key questions about family-to-family support. Questions addressed:

- common barriers/challenges experienced with the mental health system
- supports related to accessing children’s mental health services
- supports that would be helpful in moving through children’s mental health services or other services such as education, doctors or community resources
- the differences between a family support provider and that of a mental health worker
- the benefits of a family support provider
- the challenges of a family support provider
- description of the service provider role
- advice for the development of the program

Caregivers in the focus group identified schools as a primary barrier related to mental health needs of children both in terms of the lack of support and the stigma attached to them as parents. This supports the value of a cross-sector model and underscores outcomes of the Parent Connectors program (Kutash et al, 2006). In terms of accessing CMH, advocacy was the function that participants identified as most helpful and felt this should be one of the primary or ideal roles for a Family Support Provider. Also identified as helpful was the support of other families and physicians and access to reading materials. In terms of recommended changes, participants suggested more support in the school system as well as increased availability of parenting classes and parent support groups. Beyond this, caregivers felt that a Family Support Provider would offer lived experience, a perspective different from that of an agency.
Family Support Provision

worker, and would help them to navigate various systems. While participants believed Family Support Provider could lessen the feeling of isolation, they expressed concern for the mental health of these providers having to relive experiences in this role. Persons in the role must be trained and knowledgeable and must know the supports that are available to families (e.g., disability tax credits). Preliminary results from the on-line focus groups are very much in keeping with the literature but also unique in that they emphasize key roles and functions of the Family Support Provider (i.e., advocacy) and the need to work with schools and bring physicians on board. See Appendix C for preliminary report.

**The Made in Ontario Family Support Provision Model**

Parents for Children’s Mental Health and Kinark Child and Family Services propose to implement a Family Support Provision model that will assist and empower families as they interact with systems supporting their children and youth. The principles that will drive the development, implementation and evaluation of the model have been developed based on the Parent Empowerment Program (Olin et al., 2010) These 10 key principles, as well as results from the focus group, have been adapted for the Family Support Provision Model.

**Principles Underlying Family Support Provision**

1. Family support is individualized and tailored to the specific needs of families.
2. Family support facilitates linkages of families to agencies, services and to other families as well as within systems.
3. Family support is respectful and responsive to issues of diversity.
4. Family support builds skill through hands-on-training, role modeling and mentorship, and other skill-building activities.
5. Family support increases family members’ knowledge and capacity to help families make informed decisions about their child’s service needs.
6. Family support is engaging; it actively partners with families to meaningfully involve them in programs and services.
7. Family support problem solves by focusing on needs and solutions and by identifying successes of the past and options for continued success.
8. Family support focuses on outcomes and success and is goal oriented.
9. Family support broadens horizons by expanding the possibilities for family involvement (from their own community to policy levels and cultivates a community of peer support).
10. Family support promotes advocacy and empowerment.

These principles are identified in the literature but also validated by the participation of families in an on-line focus group. The principles highlight the need for linkages between agencies, services, and within systems, the responsiveness to issues of diversity, the building of knowledge and capacity, the importance of trained providers, and the importance of advocacy and empowerment. This consistency
reflects the value and importance of multiple sources of information (i.e., literature and lived experience).

**The Elements**

The proposed elements for the development of a “Made in Ontario” Family Support Provision model are:

- Family-centred, focused on the needs of both clients and family members (CAMH, 2004)
- Driven by partnerships (PCMH, Mental Health Service Providers (Kinark), and MCYS, with linkages and application to Health, Education, and Child Welfare)
- Informed by policy and evidence (MHCC, MCYS)
- The service will be overseen by a Service Leader/Co-ordinator. This is similar to the Family/Whanau Advisors in New Zealand (Taranki, 2010). The role of the Service leader is to co-ordinate and supervise Family Support Providers, monitor service fidelity, facilitate training and develop processes, policies and systems.
- The service will be delivered by Family Support Providers. This role is similar to that found in the Tapestry Model, the Targeted Parent Assistance Program, and Parent Support Partners Program (Adams et al., 2006; Becker & Kennedy, 2003; Conklin et al., 2010; Munson et al., 2009). Family Support Providers are responsible generally for providing information, connecting families to various supports and services, assisting in navigating systems and advocating for families.
- In terms of overall service structure, in this model PCMH and Kinark will share complimentary leadership roles. PCMH will be responsible for the delivery of the Family Support Provision while Kinark will oversee the project. The structure is shown in Figure 1.
- To ensure that the model is applicable across service sectors, informed by family voices, and addresses the needs of various regions, a Steering Committee, with advisory responsibility should guide the project. The Committee should consist of regional representatives from:
  - Education
  - Health
  - Children’s Mental Health
  - Child Welfare
  - Families

Steering Committee Representation is show in Figure 2. Partners would be invited from the Student Support Leadership Initiative to draw on local expertise for this type of collaborative, cross-sectoral model. Another means of including community partners is participating in the Children Services Networks in the various communities.
**Family Support Provision**

**Director, Program Services** Responsible for Family Support Provision Project

![Diagram of Family Support Provision](image)

**Legend:**
- Supervisory =

Figure 1.
Figure 2.
Initial Implementation

Kinark and Parents for Children’s Mental Health are proposing to develop and undertake a limited implementation of the ‘Made in Ontario’ model. Outcomes from this implementation will inform recommendations for a fulsome implementation across the province at some future date.

This initial implementation is informed by the emerging but limited nature of the evidence surrounding family-to-family support program and the “newness” of the proposed model, combined with the limited funding available. The initial implementation will be undertaken within four communities.

The objectives of the work that we will undertake are to:

1) To provide an initial implementation of the proposed model (see initial application, Appendix A);
2) To build the evidence for the “Made in Ontario” Family Support Model;
3) To develop the knowledge to expand and implement the model across the province.

The initial implementation of this service would consist of two Family Support Providers and one staff member of PCMH acting as the Service Lead. Due to the small scale nature of this implementation, rather than hiring and training a dedicated Coordinator position, this function will be provided by a staff member of PCMH in addition to that person’s other responsibilities. Based on the Buddy Program in British Columbia and Woodgreen Service in Toronto, it is estimated that the two Family Support Providers in this initial implementation would serve approximately 40 families in total.

To build the evidence for the model and determine costs and caseloads, PCMH and Kinark recommend a controlled comparison study of the initial implementation. In terms of the study, families entering DirectResponse (Kinark’s front door service) would be randomly selected and invited to participate with a Family Support Provider program. A random selection will help to ensure that families with a range of needs are included in the evaluation and inform the model. A second group of 40 families also would be randomly identified and their data compared with those receiving the FSP service.

Recruitment and Selection

PCMH will be responsible for recruitment of selection of Family Support Providers based on the following criteria:

- Parents/caregivers of youth with behavioral, emotional, or mental health disorders
- Parents/caregivers who have first-hand experience with the public mental health system
- Having an ability to use personal experiences and knowledge to expand opportunities for family choice and voice
- Being able to partner and engage parents and professionals
- Be a current PCMH member
• Agree to collaborate with the local PCMH chapter
• Take the certification course
• Commit to up to 18 months of support provision
• Completion of a security screening process

For the purposes of the initial implementation, PCMH will recruit two parents/caregivers to serve as Family Support Providers. The role of Family Support Provider is to:

• Assist families in identifying and prioritizing needs
• Assist in locating and accessing community programs and resources
• Provide information to aide in obtaining appropriate services
• Provide emotional support during the course of service
• Serve as a liaison and helps to build collaborative relationships between services, other service providers and families
• Assist families in developing strategies to communicate effectively with services and service providers (e.g., mental health, education, health, YJ, child welfare)
• Support families in navigating various child and youth systems and services
• Provide support and information to other service providers

PCMH also will provide a Service Lead to oversee and co-ordinate the Family Support Program. The Family Support Service Lead would work directly with Kinark’s Director, Parent and Youth Engagement and be accountable to the Director, Program Services (See Figure 1). The role of the Service Lead is to:

• Support intake and matching of families to Family Support Providers
• Co-ordinate Family Support Providers
• Work with management to establish family participation in processes and systems
• Facilitate training and on-going education Family Support Providers and the organization large
• Provide peer supervision and consultation to Family Support Providers
• Monitor fidelity of processes and model
• Assist in involving family members in policy, procedure and process development
• Assist in quality assurance process including auditing and reviewing aspects services to ensure family involvement
• Ensure best practice in family-to-family support

Pre-Service Training

Pre-service training will be provided to the PCMH Service Lead as well as the Director, Parent and Youth Engagement. A training program will be selected based on the following criteria:

• Parent Support Model that is similar to the recommended Made In Ontario model
• Staged education/certification program with built-in readiness assessment and supervision
• University-based research partnership
Professional development opportunities

Content that covers core competencies outlined by the National Federation for Families (2010) including:

- Ethics
- Confidentiality
- Effecting change
- Current child and youth behavioural information
- Communication
- Parenting for resiliency,
- Empowerment
- Advocacy in and across systems
- Cross-sectoral regulations
- Wellness and natural support

Training in the Parent Support Partners Program will be broken into four phases:

1) 3-day in-class training (including readiness assessment to begin field work)
2) 6-week field work/practicum
3) 2-day practicum review, role plays, and in-depth case study review
4) 9 months of coaching and consultation

Modifications to content areas (e.g., Cross-sectoral regulation and advocacy) will need to be made to reflect Ontario standards. This is an important role played by Steering Committee members. The Family Support Service Lead and the Director, Parent and Youth Engagement will then train the two Family Support Providers in this modified model developed with input from the Steering Committee.

Training Family Support Providers, however, is only one side of the equation. The Family Support Service Lead and Local Family Support Providers will provide Kinark Direct Service Practitioners in each area program with a one-day training session designed to describe the role of Family Support Provision, break down misconceptions of working with family professionals and build collaborative partnerships between Family Support Providers and frontline staff.

The Steering Committee will act in an oversight capacity for the PCMH Service Lead and the Kinark Family Service Lead during all phases of the work.
Decision Support Data Systems

As previously identified, an initial implementation of the model including a comprehensive evaluation is recommended. The evaluation would consist of 40 families randomly selected from across four Kinark area programs. A second group of 40 families would be invited to serve as a comparison group. Factors that would be evaluated are derived from the literature, the caregiver focus group, and the guiding principles of the model.

They include:

Client (Child/Youth):
- Improved functioning (including school)
- Reduced mental health problems

Caregiver:
- Improved family situation
- Decreased stress
- Increased knowledge of youth needs
- Increased knowledge of relevant services and supports
- Increased sense of efficacy
- Decreased sense of isolation
- High satisfaction with service

Family Support Providers:
- High satisfaction with service

Service Providers:
- Increased alliance with families
- High level of alliance with Family Support Workers
- High level of perceived effectiveness of service

Agency:
- High level of perceived effectiveness of service
- High satisfaction with FSP

Community:
- Increased levels of service integration
- Increased awareness of CMH services
- High level of perceived effectiveness of service
- High satisfaction with FSP
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Appendix A Literature Search Process
Project Title: Model(s) of Family Support Provision  
Document Type: Literature Search  
Updated as of November 26th, 2010

**Topic: Model(s) of family support provision**  
**Data Base: PsycINFO**  
**Parameters: Social Sciences Earliest to 2011**

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### Family Support Provision

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Appendix B Model Comparison
## Comparison of Family-to-Family Support Programs

v — Clear Evidence, ? — Unknown, anecdotal evidence, x — No evidence, No existence

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v - Clear Evidence, ? – Unknown, anecdotal evidence, x – No evidence, No existence

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Based on this comparison of models, existing models/programs of parent-to-parent support either do not have sufficient components and/or evidence to support their implementation. Therefore, the Made in Ontario Model is recommended for implementation. It addresses key components that have emerged in the literature and is sufficiently generic to fit to various contexts (service or geography) as it is based on functions and processes rather than sector-specific content.

Given the variety of confounding factors that can exist not only across sectors but across like services, a strong test of this single model is recommended so that factors other than the service will not impact outcomes. The ability to determine the overall effectiveness of different models would be extremely difficult. Some of the many factors that would have an impact on outcomes include geography, sector, staff training, organizational culture, and physical resources. These factors would negatively impact the ability to understand the true effectiveness of a model.
Currently, there is a dearth of strong, comparative evidence regarding parent-to-parent support. There is a significant need for a focused, well-controlled study of a comprehensive model. After sufficient evidence is obtained for one model, the next appropriate step would be to implement that model across sectors and examine how the above factors contribute to or diminish outcomes.
Advocate - An advocate is someone who speaks on behalf of another person, especially in a legal context. Implicit in the concept is the notion that the represented lacks the knowledge, skill, ability, or standing to speak for themselves. An advocate serves as a support system for the person(s) being advocated for.

Diversity - Diversity is a commitment to recognizing and appreciating the variety of characteristics that make individuals unique in an atmosphere that promotes and celebrates individual and collective achievement. Examples of these characteristics are: age; cognitive style; culture; disability (mental, learning, physical); economic background; education; ethnicity; gender identity; geographic background; language(s) spoken; marital/partnered status; physical appearance; political affiliation; race; religious beliefs; sexual orientation.

Diversity Definition: http://www.lib.utk.edu/diversity/diversity_definition.html

Empowerment – Is a concept that crosses disciplinary lines. Empowerment as a multi-dimensional social process that helps people gain control over their own lives. It is a process that fosters power in people for use in their own lives, their communities and in their society, by acting on issues they define as important. In a children’s mental health context, families are empowered by reaching their own goals. No one can “empower” someone else. Empowering families means helping them reclaim their ability to dream, and to restore their own capacity to take good care of themselves.

Family-Driven Care - Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

1. Choosing supports, services, and providers;
2. Setting goals;
3. Designing and implementing programs;
4. Monitoring outcomes;
5. Partnering in funding decisions; and
6. Determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

Grey Literature – Is information produced on all levels of government, academia, business and industry in electronic and print formats not published commercially or indexed by major databases.

Parent Advocates – Parent advocates comprise the participants identified in Munson et al.’s study (2009). Parent advocates are similar to Family Support Providers and hold experience working within systems of care. In Munson et al.’s study, the sample included parents with over twenty years of experience in advocacy and parents that had worked as advocates for six weeks.
**Peer Reviewed Literature** – Peer-reviewed literature (sometimes called refereed publications) are scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion.

**Systems of Care** - A system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. A system of care is not a program — it is a philosophy of how care should be delivered. Systems of Care is an approach to services that recognizes the importance of family, school and community, and seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural and social needs. The systems of care philosophy in children’s mental health is based on a set of principles suggesting that services need to be family focused, parent led, and strengths-based.


**WrapAround Process** - WrapAround is a process which develops and carries out plans for children, individuals and their families who have very complex needs. The WrapAround planning process follows a series of steps intended to help children, individuals and their families realize their hopes and dreams.

The WrapAround process is implemented with the involvement of those people important to the family. A WrapAround facilitator helps the family develop a team of friends, family, members of faith community, etc as well as professionals involved in a helping role. This team shares resources; problem solves, coordinates their activities and blends their perspectives of the family’s situation. Together with the family, they develop an action plan.

WrapAround improves the lives of families by building on their strengths. It encourages them to make helpful, caring connections in the community. The WrapAround process ensures that services are focused on the needs of the individual and his or her family.

Family Support Provision: Online Focus Group

Background

- There is growing evidence in the U.S. regarding the effectiveness of parent or family-to-family support programs. Family-to-family support programs offer emotional support, shared experiences, assistance with system navigation, reduction in miscommunication, translation of materials, processes, and policies and contributions to parent’s overall sense of support and empowerment.

- The purpose of this project was three-fold:
  - To include family expertise in the development of a family support provision program led by Parents for Children’s Mental Health (PCMH) and Kinark Child and Family Services (Kinark).
  - To address the gap remains in the literature that exists between professional and family voices in informing family-to-family supports.
  - To adopt a new methodology – online focus group as a means of gaining deeper insight into the issue and limiting participation barriers such as geography and schedules.

Method

- Two separate online focus groups with parents/caregivers and service providers were conducted.
- A bulletin-board style forum was used which took place over the course of 3 days.
- The focus group was moderated by research assistants using a discussion guide developed by representatives from PCMH and Kinark. The groups also were “shadowed” by managers from PCMH and Kinark to support the moderators.
- Parents/caregivers were randomly selected from a PCMH database. Interested parents were contacted and screened to ensure they were currently in service or had completed service at a children’s mental health agency.
- 12 parents/caregivers were recruited to participate in the caregiver focus group.
- Managers at Kinark were emailed and asked to inform interested staff who then were contacted by a research assistant.
- Six service providers were recruited to participate in the focus group.
- Initial analyses were conducted by scanning transcripts for common themes.
- In depth analyses will be completed using Nvivo qualitative data analyses software.

Results

DAY 1

Question 1 - Tell us a little about what brought you to seek mental health services for your family?

- Participants noted that their children were displaying challenging behaviors that they thought were unusual for a child.
- Most children were referred to mental health services, many for diagnoses of ADHD, ODD, anxiety or other concerns.

Question 2 - What common barriers/challenges have you experienced or are currently experiencing within the mental health system based on your experience?

- A lack of support within the education system was primarily identified as opposed to within the mental health system.
- Parents sensed that teachers put the blame on them for their child’s mental health concerns as an indication of poor parenting skills.
- Many parents felt there was an issue with regards to being referred to the “right” services by children’s mental health agencies and family doctors.
Results Cont’d

DAY 1

Question 3 – Based on your experience can you share with us any programs (or models) that may have worked well in accessing and moving through children’s mental health services?

- One family member noted receiving a tremendous amount of support from their case manager who follows up with the school at school meetings by advocating on her son’s behalf.
- Other parents noted that Day Treatment was a huge success.
- Support from a crisis worker at children’s mental health agency who was an advocate for the family in the school system was also mentioned.

Question 4 - Please describe the supports you feel you have received as a family, accessing children’s mental health services?

- One of the most common themes that came up when participants answered this question was the support of other parents/families. This may be formally through support groups or more informally like friends who are going through similar experiences.
- Those participants who discussed having supportive and understanding family physicians saw them as extremely helpful in accessing children’s mental health services.
- Several participants have found the book “The Explosive Child” by Ross Greene, PhD helpful in managing challenging child behaviours.

DAY 2

Question 1 - We would like you to share your ideas about supports that you think would help families get into and through children’s mental health services or other services such as education, doctors or community resources.

- A common theme among most participants was the discussion of more support provided within the school system. A need for educators to be more knowledgeable of mental health issues was mentioned by many of the participants.
- There was mention of parenting courses that might be available to parents.
- Parents also noted the desire and need for more parent support groups as a helpful tool in dealing with children’s mental illness.
- A parent/caregiver made the following point:

“Parent support groups are essential. Mental health can be a very lonely and isolating place to be. People who don’t necessarily live it, don’t want to see it, don’t want to hear about it, don’t know how to react”

Question 2 - Some family support programs have a specific person that helps families access and navigate services. These people are often other parents or caregivers who have had similar experiences to yours and are often referred to as family support providers. How do you think the role of this person would be different from that of a worker at a mental health (or other) agency?

“I have learned that no professional can really guide me as well as I need. It is only through other parents, and my own research and advocacy that I have been able to get so far”

- This sentiment was echoed among participants who answered this question. A Family Support Provider would be able to offer ‘lived experience’ to families and bring a different perspective than an agency worker.
- Through this lived experience the FSP would be able to provide moral support as well as help parents/families to access community resources.
- When probed about the specific role that a family support provider would play, a common theme was the role as a navigator between and within systems.
Results Cont’d

DAY 2

Question 3 - What do you think are some of the possible benefits to having a parent/caregiver who has been through similar experience act as a family support provider to help navigate the children’s mental health system (as well as other systems)?

- Participants all seemed to agree that having a person with shared experience would take away the sense of being alone when dealing with children’s mental health issues.
- Along with this personal connection would be the benefit of having someone experienced guide you through the system and offer advice along the way.

Question 4 - What do you think are some of the possible challenges of having another parent/caregiver act as a family support provider?

- The most common challenge articulated by participants was the concern for the family support provider’s own mental health. Parents/caregivers felt that being in this role could cause burnout or bring up painful memories/anxiety linked to this person’s own personal experience.
- When probed about whether or not they would take advantage of a family support provider, there was a common ground that yes – an FSP would be helpful – but that after years of dealing with the system many parents felt as though they had “navigated all there is to navigate”

DAY 3

Question 1 - If you could create the perfect family support role for parents, what would it look like? What would they provide for families?

- Participants felt that the FSP must have extensive knowledge as well as training for this role. Knowledge would include that of children’s mental health issues, as well as an awareness of community resources.
- Another frequently mentioned item for the ‘ideal’ family support was the advocacy they would provide for families. Not only would parents like to see them advocating for their families/children but also teaching the family how to advocate for themselves.

“Struggling with mental health can be a very lonely / isolating place and to have someone walk “beside” you not necessarily in front would be very empowering and encouraging.”

Question 2 - As a wrap up, is there anything we haven’t yet discussed that you would like to add? What is the strongest piece of advice you could give us to help in developing the family support program?

- Participants expressed the need for a quick turnaround when it came to contact with a support.

Other pieces of advice and final thoughts offered included:

- Getting doctors and family physicians on board
- Be realistic about the expectations you put on an FSP
- Must be knowledgeable and have access to resources for families
- Must have knowledge of perks available to families with children that have mental health concerns (e.g., funding, disability tax credits, special rates, etc.)

Limitations

- Though 6 service providers were recruited and agreed to participated in the online focus group over the course of 3 days there was limited participation
- Of the 6 service providers recruited only 3 logged into the focus group for a total of 9 posts over 3 days in comparison to 88 posts by 12 parents
- Of the 3 providers that logged in, only 1 logged in on all 3 days
Appendix E Competencies
## Appendix B

### Competency in Each Area Should be Rated on the Following Scale:

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### Interpersonal competency and personal skills
- Knowledge of theory and research related to interpersonal relationships and therapeutic alliance
- Knowledge of self, such as motivation, resources, values, personal biases,
- Knowledge of others, including macro-micro environment
- Presents evidence showing ability to establish and maintain rapport
- Presents evidence showing ability to establish and maintain trust and respect with client
- Demonstrates expressive skills - communicating information in a clear, organized, manner
- Demonstrates self-reflective skills in response to questions and comments (e.g., aware of own strengths and weaknesses)
- Demonstrates affective skills (e.g., both in relationship to client and in response to being examined)
- Demonstrates organizational skills (e.g., well prepared for presentation and questions, readily has case material and research literature available to answer questions)

### Competence in assessment
- Knowledge of populations, theory, assessment methods and diagnosis
- Conducts and reports on a competent assessment (selection of methods, information collection, diagnosis)
- Provides a case conceptualization & treatment plan (ties the unique characteristics of the client and the context of the client concerns into consideration, differentiates between important and unimportant details)
- Is aware of limitations in assessment and communicates ideas about how could improve assessment

### Competence in intervention
- Knowledge of interventions/approaches appropriate to client
- Provides and reports on treatment of client (e.g., selection of appropriate intervention; delivery of treatment; adaptation of approach to client and context, differentiate between important and unimportant details)
- Discusses the therapeutic relationship, including establishment and maintenance of rapport, personal biases, issues of diversity
- Presents therapeutic moments
- Is aware of limitations of treatment and communicates ideas about how could improve treatment
- Indicates how determined outcome (e.g., measures, self report, behaviours) and how could have improved assessment of outcome
- Discusses referrals and consultations as well as interdisciplinary treatment if appropriate

### Competence in research
- Presentation of research related to assessment and treatment
- Presents gaps in research knowledge that are pertinent to case
- Thinks scientifically about case; shows critical reasoning skills
- Appropriately translates research into practice

### Ethics and professionalism
- Gives appropriate attention to ethical considerations (e.g., respectful of client, appropriately disguises identifying information)
- Discusses how responded to ethical issues if these arise
- Competently answers questions about ethical issues that could arise with case
- Shows ability to resolve ethical dilemmas that emerged or is asked about
- Demonstrates professionalism during the presentation (e.g., both in how worked with client and how presents case and respond to questions)

### Supervision
- Describes role of supervision in assessment and treatment (e.g., amount, type, value); can describe what has learned in working with client and role of supervision in learning
- Demonstrates awareness of what knows and does not know
- Open to feedback on presentation; nondefensive
Appendix F Evaluation Framework
<table>
<thead>
<tr>
<th>Objectives (What does the program want to achieve?)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client (child/youth):</strong></td>
</tr>
<tr>
<td>• Improved functioning</td>
</tr>
<tr>
<td>• Reduced mental health problems</td>
</tr>
<tr>
<td><strong>Client (Parent/Caregiver):</strong></td>
</tr>
<tr>
<td>• Improved family situation</td>
</tr>
<tr>
<td>• Increased involvement in care</td>
</tr>
<tr>
<td>• Increased communication regarding youth needs</td>
</tr>
<tr>
<td>• Decreased stress</td>
</tr>
<tr>
<td>• Increased knowledge of youth needs</td>
</tr>
<tr>
<td>• Increased knowledge of CMH system</td>
</tr>
<tr>
<td>• Increased sense of efficacy within the CMH system</td>
</tr>
<tr>
<td>• Increased therapeutic alliance</td>
</tr>
<tr>
<td>• Increased engagement</td>
</tr>
<tr>
<td>• Increased knowledge of community services</td>
</tr>
<tr>
<td>• Increased sense of isolation</td>
</tr>
<tr>
<td>• High satisfaction with service</td>
</tr>
<tr>
<td><strong>Staff:</strong></td>
</tr>
<tr>
<td>• Increased alliance with families</td>
</tr>
<tr>
<td>• High level of alliance with Family Support Workers</td>
</tr>
<tr>
<td>• High level of perceived effectiveness of service and satisfaction with service</td>
</tr>
<tr>
<td><strong>Family Support Workers:</strong></td>
</tr>
<tr>
<td>• Increased alliance with families</td>
</tr>
<tr>
<td>• High level of alliance with Service Providers</td>
</tr>
<tr>
<td>• High level of perceived effectiveness of service and satisfaction with service</td>
</tr>
<tr>
<td><strong>Service:</strong></td>
</tr>
<tr>
<td>• High level of attendance</td>
</tr>
<tr>
<td>• High degree of fidelity to FSP program</td>
</tr>
<tr>
<td><strong>Agency:</strong> Maximizing agency resources</td>
</tr>
<tr>
<td><strong>Improved service quality</strong></td>
</tr>
<tr>
<td><strong>Improved policies and procedures</strong></td>
</tr>
<tr>
<td><strong>Community:</strong></td>
</tr>
<tr>
<td>• Increased levels of service integration</td>
</tr>
<tr>
<td>• Increased awareness of CMH services</td>
</tr>
<tr>
<td>• High level of perceived effectiveness of service</td>
</tr>
<tr>
<td>• High satisfaction with FSP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale (What is the theoretical/evidence-based background?)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theory:</strong></td>
</tr>
<tr>
<td>• Family empowerment (Scheer and Gavazzi, 2009)</td>
</tr>
<tr>
<td>• Family-centred care:</td>
</tr>
<tr>
<td>• the recognition that parents are the experts on their child’s needs</td>
</tr>
<tr>
<td>• practices that promote partnerships between parents and service providers</td>
</tr>
<tr>
<td>• support for the family’s role in decision making about services for their child</td>
</tr>
<tr>
<td><strong>Model:</strong></td>
</tr>
<tr>
<td>• Family-to-family support</td>
</tr>
<tr>
<td><strong>Literature Reviewed:</strong></td>
</tr>
<tr>
<td>• See comprehensive review-attached references</td>
</tr>
<tr>
<td><strong>Distinguishing Principles:</strong></td>
</tr>
<tr>
<td>• Family support is individualized and tailored to the specific needs of families</td>
</tr>
<tr>
<td>• Family support facilitates linkages of families to agencies, services, and to other families as well as within systems</td>
</tr>
<tr>
<td>• Family support is respectful and responsive to issues of diversity</td>
</tr>
<tr>
<td>• Family support builds skill through hands-on training, role modeling and mentorship, and other skill-building activities</td>
</tr>
<tr>
<td>• Family support increases family members’ knowledge and capacity to help families make informed decisions about their child’s service needs</td>
</tr>
<tr>
<td>• Family support is engaging; it actively partners with families to meaningfully involve them in programs and services</td>
</tr>
<tr>
<td>• Family support problem solves by focusing on needs and solutions and by identifying successes of the past and options for continued success</td>
</tr>
<tr>
<td>• Family support focuses on outcomes and success and is goal oriented</td>
</tr>
<tr>
<td>• Family support broadens horizons by expanding the possibilities for family involvement (from their own community to policy levels and cultivates a community of peer support)</td>
</tr>
<tr>
<td>• Family support promotes empowerment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention &amp; Client Population (What is the nature of the work and with whom?)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Support Provision Model:</strong></td>
</tr>
<tr>
<td>• Family support provision:</td>
</tr>
<tr>
<td>• Is delivered through family-to-family support by someone who is currently raising or has raised a child with emotional, behavioural or mental health challenges; has current knowledge of the children’s mental health system, has experience with, and consciousness of the struggle and recognizes the standpoint of the “family”</td>
</tr>
<tr>
<td>• Facilitates linkages</td>
</tr>
<tr>
<td>• Skill building</td>
</tr>
<tr>
<td>• Increases knowledge and capacity</td>
</tr>
<tr>
<td>• Partners with families and service providers</td>
</tr>
<tr>
<td><strong>Population:</strong></td>
</tr>
<tr>
<td>• Families of children entering services</td>
</tr>
<tr>
<td>• Initial Implementation: Kinark families</td>
</tr>
<tr>
<td>• Full Implementation: Other Children’s Services: CMH, Education, Health, CW</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activities &amp; Outputs (What are the specific things being done?)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific Activities:</strong></td>
</tr>
<tr>
<td>• Practice Lead/Co-ordinator</td>
</tr>
<tr>
<td>• Supports intake and matching of families to Family Support Providers</td>
</tr>
<tr>
<td>• Co-ordinating Family Support Providers</td>
</tr>
<tr>
<td>• Establishes family participation in processes and systems</td>
</tr>
<tr>
<td>• Facilitates training and on-going education</td>
</tr>
<tr>
<td>• Provides peer supervision and consultation to Family Support Providers</td>
</tr>
<tr>
<td>• Monitors fidelity</td>
</tr>
<tr>
<td>• Assists in involving family members in policy, procedure and process development</td>
</tr>
<tr>
<td>• Assists in quality assurance process</td>
</tr>
<tr>
<td>• Ensures best clinical practice in family-to – family support</td>
</tr>
<tr>
<td>• Family Support Provider:</td>
</tr>
<tr>
<td>• Assists families in identifying and prioritizing needs</td>
</tr>
<tr>
<td>• Assists in locating and accessing community programs and resources</td>
</tr>
<tr>
<td>• Provides support and information to families and service providers</td>
</tr>
<tr>
<td>• Serves as a liaison</td>
</tr>
<tr>
<td>• Helps to build collaborative relationships</td>
</tr>
<tr>
<td>• Assists families in developing strategies to communicate effectively</td>
</tr>
<tr>
<td>• Supports families in navigating various child and youth systems and services</td>
</tr>
<tr>
<td><strong>Outputs:</strong></td>
</tr>
<tr>
<td>• 12 peer supervision meetings</td>
</tr>
<tr>
<td>• Educational materials</td>
</tr>
<tr>
<td>• Service to 80 families:</td>
</tr>
<tr>
<td>• • 20 families per areas (York, Simcoe, Durham, Piibo/Nithid</td>
</tr>
<tr>
<td>• Meetings with parents and service providers (CMH, Education, Health, CW)</td>
</tr>
<tr>
<td>• Policies and procedures related to Family Support</td>
</tr>
<tr>
<td>Objective</td>
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<tr>
<td>-----------</td>
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<tr>
<td>(What does the program want to achieve?)</td>
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<tr>
<td><strong>Client Level (Child/Youth):</strong></td>
</tr>
<tr>
<td>Improved functioning</td>
</tr>
<tr>
<td>Reduced mental health problems</td>
</tr>
<tr>
<td><strong>Client Level (Parents/Caregivers):</strong></td>
</tr>
<tr>
<td>Improved family situation</td>
</tr>
<tr>
<td>Improved family situation</td>
</tr>
<tr>
<td>Increased involvement in care</td>
</tr>
<tr>
<td>Increased communication regarding youth needs</td>
</tr>
<tr>
<td>Decreased stress</td>
</tr>
<tr>
<td>&quot;Caregiver Needs and Strengths&quot;</td>
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<tr>
<td>Outcome</td>
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<td>Outcome</td>
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<td>Outcome</td>
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<tr>
<td>Outcome</td>
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<tr>
<td>Process</td>
</tr>
<tr>
<td>Objective</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Increased therapeutic alliance (family)</td>
</tr>
<tr>
<td>High level of alliance with Family Support Workers</td>
</tr>
<tr>
<td>High level of perceived effectiveness of service</td>
</tr>
<tr>
<td>High satisfaction with service</td>
</tr>
</tbody>
</table>

Staff Level (Family Support Provider):

<table>
<thead>
<tr>
<th>Objective</th>
<th>Type</th>
<th>Indicator</th>
<th>Measure</th>
<th>Frequency</th>
<th>Completion</th>
<th>Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>High level of alliance with Service Providers</td>
<td>Outcome</td>
<td>High ratings on alliance items</td>
<td>Staff Experience Questionnaire/Survey</td>
<td>End of initial implementation</td>
<td>Family Support Providers</td>
<td>R &amp; E</td>
</tr>
<tr>
<td>High level of perceived effectiveness of service</td>
<td>Outcome</td>
<td>High ratings on effectiveness items</td>
<td>Staff Experience Questionnaire/Survey</td>
<td>End of initial implementation</td>
<td>Family Support Providers</td>
<td>R &amp; E</td>
</tr>
<tr>
<td>High satisfaction with service</td>
<td>Process</td>
<td>High ratings on satisfaction items</td>
<td>Staff Experience Questionnaire/Survey</td>
<td>End of initial implementation</td>
<td>Family Support Providers</td>
<td>R &amp; E</td>
</tr>
<tr>
<td>Increased professional skills</td>
<td>Process</td>
<td>Number of certifications</td>
<td>Certifications from Michigan</td>
<td>During</td>
<td>Family Support Providers</td>
<td>Michigan Parent-to-Parent</td>
</tr>
<tr>
<td>Family Support Provision: Online Focus Group</td>
<td></td>
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<td>---------------------------------------------</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Increased professional skills</th>
<th>Process</th>
<th>Number of certifications</th>
<th>Peer Feedback Questionnaires</th>
<th>Quarterly</th>
<th>Family Support Providers</th>
<th>R &amp; E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased sense of efficacy</td>
<td>Outcome</td>
<td>High ratings on efficacy items</td>
<td>Peer Feedback Questionnaires</td>
<td>Quarterly</td>
<td>Family Support Providers</td>
<td>R &amp; E</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>High level of attendance</td>
<td>Process</td>
</tr>
<tr>
<td>High degree of fidelity to FSP program</td>
<td>Process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agency:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximizing agency resources</td>
<td>Process</td>
</tr>
<tr>
<td>Improved service quality</td>
<td>Process</td>
</tr>
<tr>
<td>Improved policies and procedures</td>
<td>Process</td>
</tr>
<tr>
<td>Objective</td>
<td>Type</td>
</tr>
<tr>
<td>-----------</td>
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</tr>
<tr>
<td>Community:</td>
<td></td>
</tr>
<tr>
<td>Increased levels service integration</td>
<td>Outcome</td>
</tr>
<tr>
<td>High level of awareness of CMH services</td>
<td>Outcome</td>
</tr>
<tr>
<td>High level of perceived effectiveness of service</td>
<td>Outcome</td>
</tr>
<tr>
<td>High satisfaction with FSP</td>
<td>Process</td>
</tr>
</tbody>
</table>
## Appendix 2 – York/Simcoe Chart

<table>
<thead>
<tr>
<th>Criteria</th>
<th>York</th>
<th>Simcoe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diverse communities: Urban/rural: ethnocultural</td>
<td>Urban/rural South Asian</td>
<td>Urban/rural Aboriginal</td>
</tr>
<tr>
<td>Distance between communities</td>
<td>Large Region – there are areas of concentration of ethnocultural groups, Markham, Keswick, Vaughan, Georgina Island</td>
<td>If we were to identify our 4 communities as Barrie (urban), rural (North Simcoe), FNMI and the Best Start Hub pilot in Penetang, distance not an issue</td>
</tr>
<tr>
<td>PCMH chapter</td>
<td>Yes (YC leader)</td>
<td>Yes (strong)</td>
</tr>
<tr>
<td>Active parent engagement staff</td>
<td>Yes – we have had good support from workers at all levels i.e. admin, front line workers as well as supervisors and PD.</td>
<td></td>
</tr>
<tr>
<td>Cohesive planning tables</td>
<td>Good history of collaboration – good cross section of cross sectoral representation</td>
<td>Yes – Coalition Council, Planning Table, COMPASS/SSLI, LHIN/Coalition Steering Committee</td>
</tr>
<tr>
<td>Strong mental health in school board</td>
<td>Yes (COMPASS)-Compass Leadership, SSLI</td>
<td>Yes (COMPASS + SMCDSB = ASSIST)</td>
</tr>
<tr>
<td>Strong relationship with CAS</td>
<td>CAS is a regular participant/partner in many initiatives</td>
<td>Yes</td>
</tr>
<tr>
<td>Positive relationship with Healthcare providers</td>
<td>Hospitals are well represented - Several healthcare professionals now participating in ASD working groups</td>
<td>Yes – LHIN/Coalition Steering Committee; the CHG’s in Barrie and Midland, Family Health Teams in Barrie and Midland, CMHA, hospitals, etc.</td>
</tr>
<tr>
<td>Range of Relevant Health Services</td>
<td>yes</td>
<td>See above</td>
</tr>
<tr>
<td>Current Activities and ability to Support the FSP project</td>
<td>There is considerable focus and work happening on access and navigation in CMH and ASD because we are a large region and there are several organizations - it is still somewhat political. It would be important that this work was experienced as an integrated component of the work already happening</td>
<td>Current activities have included establishing/hosting a PCMH Parent Support Group that meets monthly; supporting/promoting PCMH Simcoe staff resources supporting these initiatives include an identified Parent Liaison worker (Bernadette), PD assistance/guidance, provision of Simcoe staff “guest speakers” as well as admin support for promotion</td>
</tr>
<tr>
<td>Interest in the FSP project</td>
<td>This initiative is very aligned with the work happening in ASD</td>
<td>High – very High!</td>
</tr>
</tbody>
</table>
Appendix 3 – FSP Job Posting

Family Support Provider
Location: York and Simcoe Counties
Two Temporary, Full-time Positions -12 Month Contract

The role of the Family Support Provider is to provide peer support and system navigation to families in the children’s mental health system and to work collaboratively with service providers to support systems change by increasing family involvement and service providers’ understanding of how to work in partnership with families for the best outcomes for children and youth. As Family Support Provider you will provide active, hands-on peer support to families of children in settings in agencies, in family homes and in community environments. The successful candidate will be responsible for the following:

Assisting families in identifying and prioritizing their needs

- Assist families to locate and access programs and resources to meet their identified needs
- Be a resource to families as they engage in service by providing information and emotional support, serve as a liaison and help to build collaborative relationships between services, other service providers and families
- Assist families in developing strategies to communicate effectively with services and service providers (e.g., mental health, education, health, YJ, child welfare)

The successful candidate will need to have experience in the child and youth services system as a family member (biological, adoptive, kin parent, or other) of a child or youth receiving services (i.e. mental health, child welfare or youth justice) and lived experience as the primary caregiver of a child or youth with emotional or behavioral challenges. The successful candidate should have a high school diploma. This position also requires that you have a valid driver’s license, access to a vehicle, and are willing to travel within the region/county and work flexible hours including evenings and some weekends. Computer competency and excellent communication skills are also a requirement, as is knowledge of local community resources.

If you are interested in this challenging position, please submit your résumé, in confidence, quoting file number FSP2012, by March 31, 2012 to:

Parents for Children’s Mental Health
Attention: Sarah Cannon, Executive Director
45 Densgrove Drive,
St. Catharines, Ontario L2M 3M1
Or electronically to scannon@cogeco.ca

Parents for Children’s Mental Health is a Provincial, non-profit organization representing the voice of families in Ontario raising children and youth with mental illness

We encourage applicants from diverse cultures. While we thank all applicants, only those selected for an interview will be contacted. Any information obtained during the course of recruitment will be used for employment recruitment purposes only, and not for any other purpose.
Appendix 4 – PCMH FSP Policies and Supervision Guidelines

Progressive Discipline Policy

Policy Statement
Parents for Children’s Mental Health will endeavor, whenever possible, to employ a progressive disciplinary system up to and including termination of employment in the event of violations of policies, practices, regulations and codes of conduct. Immediate dismissal may be appropriate in exceptional circumstances.

Purpose
To ensure fair and equitable supervisory practices in support of Agency standards and expectations of on-the-job behavior.

Standards
- Progressive discipline is defined as moving from the mildest, (verbal warning) to the strongest, (termination). It is not limited to repetition of the original offense, but may address various offenses. Depending upon the nature of the offense, the discipline and its imposition may start at any step upon the continuum as noted below.

- Any discussion of an employee’s performance or on the job conduct must include strategies for resolving the issues within a reasonable and specified period of time.

- In instances where the issue continues and/or is deemed to be of serious nature the supervisor must consider progressive steps.

- The level of discipline taken may vary depending upon the seriousness and impact of the issue. The philosophy of progressive discipline will be applied, whenever possible, in disciplinary situations.

- Progressive discipline includes verbal warning, written warning, suspension with pay, suspension without pay and termination.

- A suspension with or without pay may be imposed for a set duration of no less than one day.

- All termination must be approved by the Executive Director.

- Contents of the disciplinary letter will include;
  - Type of discipline warning, written, suspension, hand delivered to (employees name) on (date) at the top of the page.
  - Summary of the issue.
  - Possible consequences of such further action.
  - Possible suggestions for resolving the problems within a reasonable and specified period of time.

- The employee should receive the original letter via hand delivery, whenever possible, in the disciplinary meeting.
The letter must be signed by the supervisor or delegate.

The Executive Director, or delegate must be consulted before any discipline involving written disciplinary notice; suspension from work, paid or unpaid; or termination can proceed.

Roles and Responsibilities
Supervisors are Responsible for:
- Consulting with the second level supervisor and making recommendations for corrective and/or disciplinary action.
- Consulting with the second level supervisor before proceeding with progressive discipline and/or the development of corrective action, i.e., workplan.

A. Verbal Warning
- Scheduling a disciplinary meeting with the employee
- The supervisor and employee will meet at which time the supervisor will deliver the verbal warning.
- The verbal warning is confirmed in a written format for the supervision file.
- Where the supervisor has a concern with an employee’s performance or conduct, the supervisor will address the issue with the employee as soon as possible.

B. Written Warning
- Scheduling a disciplinary meeting with the employee
- Meeting with the employee and delivering the written disciplinary letter
- The employee will be provided with the original and a copy kept for the personnel file.

C. Suspension Without Pay
- Scheduling a disciplinary meeting with the employee
- Meeting with the employee and second level supervisor to impose the suspension, confirmed in writing.
- The employee will be provided with the original and a copy kept for the personnel file.
- Recording of the suspension to payroll.

D. Termination
- The length of notice period or the amount of pay in lieu of notice must be approved by the Executive Director.
- Meeting with the employee in the presence of a third party, i.e., the next level supervisor and/or another representative of PCMH.
- Providing the employee with written confirmation of the terms of the termination.
- Documenting the meeting and forwarding the documentation for placement in the personnel file.
- Collecting all Agency property.
- Approving the timecard accurately within the pay period and making any edits/adjustments to the final hours worked and to be paid.
- Removing the employee’s access to the Agency systems by alerting the help desk on the last day of work.
Duty to Report Policy

Taken from - Child and Family Services Act
R.S.O. 1990, CHAPTER C.11

Please review and become familiar with the Duty to Report portion of the Child and Family Services Act as below. If you have any questions about concerns you have please employ the following process:

1) Speak with the clinical lead of the family team, and/or the Director of Services of the Agency you are linked with
2) Inform your Supervisor of your concern/conversations with above
3) If deemed appropriate, following the processes outlined and highlighted in the excerpt below, report to the local Child Welfare office
4) Document your conversation and provide copies to your Supervisor/Service Lead of the FSP Program, the clinical lead of the family team, the Director of Service of the Agency you are linked with.

Duty to report child in need of protection

72. (1) Despite the provisions of any other Act, if a person, including a person who performs professional or official duties with respect to children, has reasonable grounds to suspect one of the following, the person shall forthwith report the suspicion and the information on which it is based to a society:

1. The child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's,
   i. failure to adequately care for, provide for, supervise or protect the child, or
   ii. pattern of neglect in caring for, providing for, supervising or protecting the child.

2. There is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,
   i. failure to adequately care for, provide for, supervise or protect the child, or
   ii. pattern of neglect in caring for, providing for, supervising or protecting the child.

3. The child has been sexually molested or sexually exploited, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child.

Note: On a day to be named by proclamation of the Lieutenant Governor, paragraph 3 is repealed by the Statutes of Ontario, 2008, chapter 21, subsection 3 (1) and the following substituted:

3. The child has been sexually molested or sexually exploited, including by child pornography, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child.

See: 2008, c. 21, ss. 3 (1), 6.
4. There is a risk that the child is likely to be sexually molested or sexually exploited as described in paragraph 3.

5. The child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child’s parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment.

6. The child has suffered emotional harm, demonstrated by serious,
   i. anxiety,
   ii. depression,
   iii. withdrawal,
   iv. self-destructive or aggressive behaviour, or
   v. delayed development,
   and there are reasonable grounds to believe that the emotional harm suffered by the child results from the actions, failure to act or pattern of neglect on the part of the child’s parent or the person having charge of the child.

7. The child has suffered emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 and the child’s parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to remedy or alleviate the harm.

8. There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 resulting from the actions, failure to act or pattern of neglect on the part of the child’s parent or the person having charge of the child.

9. There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 and that the child’s parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to prevent the harm.

10. The child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child’s development and the child’s parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, treatment to remedy or alleviate the condition.

11. The child has been abandoned, the child’s parent has died or is unavailable to exercise his or her custodial rights over the child and has not made adequate provision for the child’s care and custody, or the child is in a residential placement and the parent refuses or is unable or unwilling to resume the child’s care and custody.

12. The child is less than 12 years old and has killed or seriously injured another person or caused serious damage to another person’s property, services or treatment are necessary to prevent a recurrence and the child’s parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, those services or treatment.

13. The child is less than 12 years old and has on more than one occasion injured another person or caused loss or damage to another person’s property, with the encouragement of the
person having charge of the child or because of that person’s failure or inability to supervise the child adequately. 1999, c. 2, s. 22 (1).

Note: On a day to be named by proclamation of the Lieutenant Governor, section 72 is amended by the Statutes of Ontario, 2008, chapter 21, subsection 3 (2) by adding the following subsections:

**Reporting child pornography**

(1.1) In addition to the duty to report under subsection (1), any person who reasonably believes that a representation or material is, or might be, child pornography shall promptly report the information to an organization, agency or person designated by a regulation made under clause 216 (c.3). 2008, c. 21, s. 3 (2).

**Seeking out child pornography not required or authorized**

(1.2) Nothing in this section requires or authorizes a person to seek out child pornography. 2008, c. 21, s. 3 (2).

**Protection of informant**

(1.3) No action lies against a person for providing information in good faith in compliance with subsection (1.1). 2008, c. 21, s. 3 (2).

**Identity of informant**

(1.4) Except as required or permitted in the course of a judicial proceeding, in the context of the provision of child welfare services, otherwise by law or with the written consent of an informant, no person shall disclose,

- (a) the identity of an informant under subsection (1) or (1.1),
  - (i) to the family of the child reported to be in need of protection, or
  - (ii) to the person who is believed to have caused the child to be in need of protection; or
- (b) the identity of an informant under subsection (1.1) to the person who possessed or accessed the representation or material that is or might be child pornography. 2008, c. 21, s. 3 (2).

**Retaliation against informant prohibited**

(1.5) No person shall dismiss, suspend, demote, discipline, harass, interfere with or otherwise disadvantage an informant under this section. 2008, c. 21, s. 3 (2).

See: 2008, c. 21, ss. 3 (2), 6.

**Ongoing duty to report**

(2) A person who has additional reasonable grounds to suspect one of the matters set out in subsection (1) shall make a further report under subsection (1) even if he or she has made previous reports with respect to the same child. 1999, c. 2, s. 22 (1).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (2) is repealed by the Statutes of Ontario, 2008, chapter 21, subsection 3 (3) and the following substituted:
Ongoing duty to report

(2) A person who has additional reasonable grounds to suspect one of the matters set out in subsection (1) or to believe that a representation or material is, or might be, child pornography under subsection (1.1) shall make a further report under subsection (1) or (1.1) even if he or she has made previous reports with respect to the same child. 2008, c. 21, s. 3 (3).

See: 2008, c. 21, ss. 3 (3), 6.

Person must report directly

(3) A person who has a duty to report a matter under subsection (1) or (2) shall make the report directly to the society and shall not rely on any other person to report on his or her behalf. 1999, c. 2, s. 22 (1).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (3) is repealed by the Statutes of Ontario, 2008, chapter 21, subsection 3 (3) and the following substituted:

Person to report directly

(3) A person who has a duty to report under subsection (1) or (2) shall make the report directly to the society, a person who has a duty to report under subsection (1.1) shall make the report directly to any organization, agency or person designated by regulation to receive such reports, and such persons shall not rely on any other person to report on their behalf. 2008, c. 21, s. 3 (3).

See: 2008, c. 21, ss. 3 (3), 6.

Offence

(4) A person referred to in subsection (5) is guilty of an offence if,

(a) he or she contravenes subsection (1) or (2) by not reporting a suspicion; and

(b) the information on which it was based was obtained in the course of his or her professional or official duties. 1999, c. 2, s. 22 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, section 72 is amended by the Statutes of Ontario, 2008, chapter 21, subsection 3 (4) by adding the following subsections:

Same

(4.1) A person is guilty of an offence if the person fails to report information as required under subsection (1.1). 2008, c. 21, s. 3 (4).

Same

(4.2) A person is guilty of an offence if the person,

(a) discloses the identity of an informant in contravention of subsection (1.4); or

(b) dismisses, suspends, demotes, disciplines, harasses, interferes with or otherwise disadvantages an informant in contravention of subsection (1.5). 2008, c. 21, s. 3 (4).

See: 2008, c. 21, ss. 3 (4), 6.

Same

(5) Subsection (4) applies to every person who performs professional or official duties with respect to children including,
(a) a health care professional, including a physician, nurse, dentist, pharmacist and psychologist;
(b) a teacher, person appointed to a position designated by a board of education as requiring an early childhood educator, school principal, social worker, family counsellor, operator or employee of a day nursery and youth and recreation worker;
(b.1) a religious official, including a priest, a rabbi and a member of the clergy;
(b.2) a mediator and an arbitrator;
(c) a peace officer and a coroner;
(d) a solicitor; and
(e) a service provider and an employee of a service provider. 1999, c. 2, s. 22 (3); 2006, c. 1, s. 2; 2010, c. 10, s. 23.

Same
(6) In clause (5) (b), “youth and recreation worker” does not include a volunteer. 1999, c. 2, s. 22 (3).

Same
(6.1) A director, officer or employee of a corporation who authorizes, permits or concurs in a contravention of an offence under subsection (4) by an employee of the corporation is guilty of an offence. 1999, c. 2, s. 22 (3).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (6.1) is repealed by the Statutes of Ontario, 2008, chapter 21, subsection 3 (5) and the following substituted:

Same
(6.1) A director, officer or employee of a corporation who authorizes, permits or concurs in a contravention of an offence under subsection (4) or (4.1) by an employee of the corporation is guilty of an offence. 2008, c. 21, s. 3 (5).

See: 2008, c. 21, ss. 3 (5), 6.

Same
(6.2) A person convicted of an offence under subsection (4) or (6.1) is liable to a fine of not more than $1,000. 1999, c. 2, s. 22 (3).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (6.2) is repealed by the Statutes of Ontario, 2008, chapter 21, subsection 3 (6) and the following substituted:

Penalty
(6.2) A person convicted of an offence under subsection (4), (4.1), (4.2) or (6.1) is liable to a fine of not more than $50,000 or to imprisonment for a term of not more than two years, or to both. 2008, c. 21, s. 3 (6).

See: 2008, c. 21, ss. 3 (6), 6.

Section overrides privilege
(7) This section applies although the information reported may be confidential or privileged, and no action for making the report shall be instituted against a person who acts in accordance with this
section unless the person acts maliciously or without reasonable grounds for the suspicion. R.S.O. 1990, c. C.11, s. 72 (7); 1999, c. 2, s. 22 (4).

Exception: solicitor client privilege

(6) Nothing in this section abrogates any privilege that may exist between a solicitor and his or her client. R.S.O. 1990, c. C.11, s. 72 (8).

Conflict

(9) This section prevails despite anything in the *Personal Health Information Protection Act, 2004.* 2004, c. 3, Sched. A, s. 78 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 2008, chapter 21, section 4 by adding the following section:

**Action by organization receiving report of child pornography**

72.0.1 (1) An organization, agency or person that obtains information on child pornography under subsection 72 (1.1) shall review the report and, if it reasonably believes that the representation or material is or might be child pornography, it shall report the matter to a society or a law enforcement agency, or to both as necessary. 2008, c. 21, s. 4.

Annual report

(2) The organization, agency or person shall prepare and submit to the Minister an annual report with respect to its activities and actions relating to information it obtains on child pornography, and the Minister shall submit the report to the Lieutenant Governor in Council and then table the report in the Assembly if it is in session or, if not, at the next session. 2008, c. 21, s. 4.

See: 2008, c. 21, ss. 4, 6.

**Duty of society**

72.1 (1) A society that obtains information that a child in its care and custody is or may be suffering or may have suffered abuse shall forthwith report the information to a Director. 1999, c. 2, s. 23 (1).

**Definition**

(2) In this section and sections 73 and 75,

“to suffer abuse”, when used in reference to a child, means to be in need of protection within the meaning of clause 37 (2) (a), (c), (e), (f), (f.1) or (h). 1999, c. 2, s. 23 (1).

**Duty to report child’s death**

72.2 A person or society that obtains information that a child has died shall report the information to a coroner if,

(a) a court made an order under this Act denying access to the child by a parent of the child or making the access subject to supervision;

(b) on the application of a society, a court varied the order to grant the access or to make it no longer subject to supervision; and

(c) the child subsequently died as a result of a criminal act committed by a parent or family member who had custody or charge of the child at the time of the act. 2006, c. 24, s. 1.
Email Acceptable Use Policy

Purpose
The purpose of this policy is to outline appropriate and inappropriate use of PCMH’s email systems and services in order to minimize disruptions to services and activities, as well as comply with applicable policies and laws.

Policy
Email is a primary means of communication; therefore the agency will provide access to email systems for users as required. The email system and its contents, being property of the agency, should be restricted to use for agency business and must reflect the professional standards expected of each employee. The agency reserves the right to monitor any and all email traffic passing through its email systems.

Scope
This policy applies to all email systems and services owned PCMH, all email account users/holders at PCMH (both temporary and permanent), and all agency email records.

General Expectations of End Users

The agency often delivers official communications via email. As a result, employees with email accounts are expected to check their email in a consistent and timely manner as is appropriate for their position, so that they are aware of important agency announcements and updates, as well as for fulfilling business and role-oriented tasks.

Email users are responsible for mailbox management, including organization and cleaning. If a user subscribes to a mailing list, he or she must be aware of how to unsubscribe from the list, and is responsible for doing so in the event that their current email address changes.

Email users are expected to remember that email sent from the agency’s email accounts reflects on the agency. Please comply with normal standards of professional and personal courtesy and conduct.

Email messages are often sent to multiple recipients. As a result, users are expected to be cognizant of possible recipients when replying to emails. The use of the reply-to-all function should be carefully considered.

Appropriate Use

Individuals at PCMH are encouraged to use email to further the goals and objectives of the agency. The types of activities that are encouraged include:
- Communicating with fellow employees, business partners, and clients within the context of an individual’s assigned responsibilities while adhering to the Code of Conduct
- Acquiring or sharing information necessary or related to the performance of an individual's assigned responsibilities.
- Participating in educational or professional development activities.
Inappropriate Use

Individual email use will not interfere with others’ use of email system and services. Email use will comply with all applicable laws, all policies, and all contracts.

The following activities are deemed inappropriate uses of email systems and services and are prohibited:

- Use of email for illegal or unlawful purposes, including copyright infringement, obscenity, libel, slander, fraud, defamation, plagiarism, harassment, intimidation, forgery, impersonation, soliciting for illegal pyramid schemes, and computer tampering (e.g. spreading of computer viruses).
- Use of email for the creation or distribution of any disruptive or offensive messages, including offensive comments about race, gender, hair colour, disabilities, age, sexual orientation, pornography, religious beliefs and practices, political beliefs, national origin or of a harassing nature.
- PCMH prohibits use of its email systems and services for unsolicited mass mailings, non-PCMH commercial activity or fundraising, political campaigning, dissemination of chain letters, jokes, pictures and use by non-employees.
- Use of email in any way that violates policies, rules, or administrative orders, including, but not limited to, the PCMH Social Media Policy and Procedure.
- Viewing, copying, altering, or deletion of email accounts or files belonging to PCMH or another individual without authorized permission.
- Sending of unreasonably large email attachments.
- Opening email attachments from unknown or unsigned sources. Attachments are the primary source of computer viruses and should be treated with utmost caution.
- Forwarding emails from the agency system to external addresses without justifiable business need is prohibited (i.e. forwarding email from agency to your personal Hotmail account).
- Sharing email account passwords with another person, or attempting to obtain another person’s email account password. Email accounts are only to be used by the registered user, except in the occurrences of managed mailboxes (e.g. admin@pcmh.ca).

Monitoring and Confidentiality

The email systems and services used are owned by the agency, and are therefore its property. This gives PCMH the right to monitor any and all email traffic passing through its email.
FSP Safety Guidelines

Introduction to Guidelines:

The guidelines in this document are intended to support the premise of ensuring the safety family support providers, especially when working in home and community settings that have the potential for volatility with minimal support available.

Preparing for Home and Community Based Sessions:

For first session visits, please let your supervisor know via either phone call, text message, or blackberry messenger when you are entering the home and how long you intend the appointment to last. When leaving the appointment, let your supervisor know that you have completed the appointment and have left.

Prior to Home and Community Based Sessions where environment is unfamiliar:

• Review available information, client history and documents for matters pertaining to your safety and well-being
• Discuss identified issues or concerns (such as information gathered from a referral source or through the telephone interview) with a supervisor and make alternate arrangements for a meeting place if indicated
• Conduct client meetings at the office or another secured location where there is a known history of client or family violence
• Plan your travel time, secure a map of the location, check the directions and utilize internet search options and if applicable, note schools, police and fire stations and crime activity
• If your meeting takes place in a high crime area, schedule visits accordingly and ensure that the setting for the meeting meets the needs and purpose of your meeting and add secondary safety precautionary procedures as needed
• Enquire if pets are in the home, ask about general temperament with visitors and if medical issues or safety is concerning, request that the animal be put in a secured location during the visit
• Confirm your whereabouts and timeline for session completion with a team member or according to specific program guidelines
• If you are travelling through inclement weather, make arrangements for checking in accordingly (such as when you arrive home rather than when the session ends)
• Ensure that your whereabouts are known by others through the use of Google Apps Calendar and other tools such as BBM, Text, Phone
• Charge cell phones, equip your car with a battery charger and test the phone for roaming access prior to the onset of the meeting
• Utilize cell phone to program familiar and necessary numbers such as 911, hospital and emergency contacts
• Leave personal valuable in the automobile trunk

Conducting Home and Community Based Sessions:
• As you enter the home, look for exits and optimal location to conduct the session such as areas close to the exit and where you face the door. Do not conduct a session in a bedroom.
• In addition to asking who is in the home at that time, notice clues such as shoes, cigarette butts, and music. Be mindful of who is supposed to be in the house. If there are people whose identity is unknown, ask their identity and role in the meeting. If your evaluation of the response challenges your sense of safety, reschedule the appointment and leave the home. Report your concerns and reasons to your supervisor.
• Perform a cursory search for objects that could potentially be used as weapons, i.e. heavy objects such as ashtrays, knives, hockey sticks.
• Modify the environment, move away from controllable distractions and settle in to a room or at a table in a suitable location for what you have planned.
• If someone in the home appears to be impaired or under the influence of alcohol or other drugs, if someone whose inappropriate dress challenges your sense of comfort, or if, for any other reason, you sense an instinctual unrest, do not stay. Instead, reach a safe place outside the setting and contact a supervisor immediately, notifying them of the circumstance and of your location.
• Contact 911 for perceived emergencies and do not remain in the setting if personal safety will be compromised while 911 is contacted.
• When departing from the meeting, keep your keys in your hand when walking to the car and check in and under your vehicle.

Client and Service Participant Communications:

• Provide only business contact numbers.
• Calls made from a staff home will be made only if a number blocking feature is available, such as *67.
• Limit personal information and pictures listed on internet sites such as Facebook, do not include or “friend” clients on social media outlets from any personal accounts.

Ongoing Issues:

• Conduct regular evaluation of safety mechanisms to support a high level of competency and capacity to provide service.
• Seek supervision whenever a change in circumstance may lead to a revision to a current safety protocol.
• Note intersections, hospitals and stores as you drive into the area of the meeting.
Sick Day Policy

Purpose:

To maintain viable plans which provide income continuance when employees are off the job due to illness or injury

Standards:

- FSPs will receive 5 paid sick days/year
- Sick days in the first three months of employment are unpaid
- Any absence in excess of three consecutive shifts must be supported by a medical certificate substantiating the absence and to provide clearance for the return to work. Failure to provide the required documentation may result in the absence being unpaid and may impact on the return to the workplace
- Every effort should be made to contact the supervisor as soon as sick time will be required allowing as much time as possible to reschedule work load, or appointment obligations
- When calling in to request sick day, FSP should have day schedule available to report to Supervisor any appointments that will need to be rescheduled and provide the contact information for those appointments

Employees are Responsible for:

- Contacting the supervisor prior to the scheduled start time as soon as possible to allow for necessary work obligation planning
- Provide medical certificate for absences in excess of three consecutive days/shifts
- The medical documentation will note that the employee has been under a doctor’s care, the period of care, the employee’s ability/inability to return to work; expected date of return to work and/or re-assessment date

Supervisors are Responsible for:

- Re-assigning/re-scheduling work obligations after a sick call
- Consulting with employee to confirm attendance for next scheduled shift
- Advising the employee where absence exceeds three consecutive days to provide confirmation in support of the absence
- Recording absences and reporting to payroll

Where medical documentation is required and not provided, communicating with payroll absence will be unpaid.
Vacation Request Policy

Standards:

- The vacation year will be defined as June 1 to May 31st
- FSPs will be eligible for two-week’s paid vacation
- Vacation will not be approved during the first three months of employment
- Vacation pay is included on bi-weekly pay cheques, therefore, vacation days will be deducted from regular pay schedules

Approval and Scheduling Vacation

- Vacation must be requested in writing and every effort should be made to submit for approval one month prior to the date vacation commences
- Advanced approval is required before any requested vacation can be taken
- Vacation must be approved by the immediate supervisor. Supervisor’s decision is final
- Approvals must be in writing
- While every effort is made to meet vacation requests, the supervisor will take into consideration work requirements and obligations when reviewing requests. Please be respectful of this process and potential limitations regarding vacation scheduling
- No vacation can be taken between the time a resignation is submitted and the effective date of the resignation unless approval for the vacation predated the resignation by at least one month
- Where an employee is given notice of termination, no vacation can be taken between the date of the notice and the last day of the notice period unless the approval for vacation predated the notice by at least one month

Employees are Responsible for:

- Make the requests for vacation to direct supervisor in writing
- Make every effort to request vacation at least one month prior to the vacation commencing
- Respect supervisor’s decision, and parameters within which the decision was made

Supervisors are Responsible for:

- Approving or denying requests in writing
- Ensure employees are taking scheduled vacations
- Communicating with Payroll regarding scheduled vacations
Mobile Phone Security Policy

In order to protect the information and data of Kinark Child and Family Services, Parents for Children’s Mental Health, and the clients of the Family Support Providers, Family Support Providers must abide by these mobile security policies.

1. Any phone or mobile device that stores any data used or collected in the role of and during the duties of performing family support must have the following security measures put in place:
   - A screen lock must be implemented to require a password or code to be entered after the phone has been idle for 2 minutes or more
   - The screen lock must not be the default passwords provided by the phone or voicemail service. A new password must be created and be deemed to be secure
   - Contacts/Address books must not contain any identifying information of the client (i.e., recording of their address). Contacts should be recorded in a way that does not allow identification of the client should the phone be lost or stolen
   - Weekly downloading of texts, emails, messaging, or any other communications must be completed using the desktop software supplied with the phone, and stored in secure files as laid out in the Privacy and Confidentiality and storage of information provided in orientation
   - After weekly downloading, all files, texts, emails, and messaging must be wiped from the phone

2. Addition of any data obtained during the function of providing Family Support either client information or data owned by either Kinark Family and Child Services or Parents for Children’s Mental Health to personal phones is prohibited.

3. In addition you agree to the following:
   - You will report any loss or theft of the phone or mobile device to management within 24 hours
   - You consent to having your phone or mobile device data wiped in the event of a loss or theft to protect any data stored on the device
   - You agree to abide by best practices in this and other technology policies which can be amended by management at any time.

Employees in possession of company equipment such as cellular phones are expected to protect the equipment from loss, damage or theft. Upon resignation or termination of employment, or at any time upon request, the employee may be asked to produce:

1. the phone for return or inspection. Employees unable to present the phone in good working condition within the time period requested (for example, 24 hours) may be expected to bear the cost of a replacement.
2. Employees who separate from employment with outstanding debts for equipment loss or unauthorized charges will be considered to have left employment on unsatisfactory terms and may be subject to legal action for recovery of the loss.

3. Safety must come before all other concerns. Regardless of the circumstances, including slow or stopped traffic, employees are strongly encouraged to pull off to the side of the road and safely stop the vehicle before placing or accepting a call. If acceptance of a call is unavoidable and pulling over is not an option, employees are expected to keep the call short, use hands-free options, refrain from discussion of complicated or emotional discussions and keep their eyes on the road. Special care should be taken in situations where there is traffic, inclement weather or the employee is driving in an unfamiliar area.

4. In situations where job responsibilities include regular driving and accepting of business calls, hands-free equipment will be provided to facilitate the provisions of this policy.

5. Employees who are charged with traffic violations resulting from the use of their phone while driving will be solely responsible for all liabilities that result from such actions.

Violations of this policy will be subject to the highest forms of discipline, including termination.
Expense Reimbursement Policy

PURPOSE

To ensure that business costs incurred by employees, and other volunteers are recorded and reimbursed in an equitable and timely manner.

POLICY

Reasonable business expenses incurred by an employee, or volunteer on behalf of the Agency will be reimbursed to the claimant by the Agency on a monthly basis.

Reasonable personal expenses incurred by the Agency on behalf of an employee, will be reimbursed in a timely manner. The Agency will establish the terms and conditions of employee and volunteer expense incurrence and will disburse and collect payments utilizing a fully documented system of verification, proof of payment, and proper approval.

Please submit claims for reimbursement to the Executive Director of PCMH:

- On PCMH claim form
- Accompanied by all receipts
- Prior approval from supervisor where required
- Expenses will be submitted monthly to the Executive Director of PCMH
- All expenses to be documented with receipts and explanation of expenditure
- If expenses are not submitted monthly, payments may be withheld.

Transportation

- Reimbursement for travel by car will be at the rate of $0.42/km
- Parking expenses are covered on submission of receipts

Hotel Accommodations

When overnight accommodations are required and not covered by a sponsoring agency, hotel expenses may be reimbursed by PCMH with prior approval. Many hotels will give a “government” rate if you describe the work you are doing for the association. Failing that, the lowest possible rate is encouraged. Prior approval must be given before accommodations will be reimbursed.

Meals

*Meal Allowances*: Meal costs will be reimbursed at a maximum per diem amount of $65.00 (CDN) per day broken down as follows: $10.00 for *breakfast*, $20.00 for *lunch* and $35.00 for *supper*, upon presentation of official receipt.
Supervision Rationale and Guidelines

What is Supervision for FSP?

- Accomplish organizational missions and outcomes
- Support staff to do assigned work
- Facilitate the development of staff
- Partner with system peers to implement the principles of Family Support Provision
- Ensure fidelity to the principles and foundation of the FSP service provision model

What are the roles of a Supervisor with the FSPs?

- Orient new employees and motivate all direct reports
- Teach organizational procedures
- Teach strength-based practice skills
- Provide strength-based case review and feedback
- Monitors staff progress including review of assignments and goals
- Initiate and support professional development
- Develop and maintain FSP program level communication
- Work together to improve individual case process
- Ensure the best use of resources
- Provide support for FSPs in their role as a support person
- Regularly meet with FSPs to review and maintain fidelity to the program

What are the roles of the Supervisor in the partnership with an agency?

- Trouble shoot cross-system conflict resolution using strength-based approach
- Cross-system manager and program developer
- Develop goals and procedures that support FSPs and child and family outcomes

Develop and implement cross-system quality improvement and training opportunities

Supervision Agreement

This document reflects a commitment between (Supervisor) and (Supervisee) to agree to the following supervision guidelines.

The purpose of supervision is to:

- Provide protected time with the sole focus on the Family Support Provider work including review of adherence and commitment to the FSP Core Values and principles of wraparound rather than managerial tasks.
- Provide a forum to address professional development and related administrative responsibilities required to meet standards of the Family Support Provider Program.
- Provide effective and improved family outcomes by supporting staff in their work.
Foundational Principles in Supervision

- **Responsiveness** – demonstration of a receptiveness to experiences and/or development requirements of supervisees within the scope of evidence-based practice;
- **Reciprocity** – the mutual responsibility of the supervisor/supervisee to ensure a high quality of service and ongoing professional development;
- **Consultation** – when the specifics of a particular case are beyond the expertise of the supervisory relationship, supervision will provide access to other expert consultation;
- **Structure and consistency** – formal and structured supervision occurs regularly and is to be consistent with FSP Program standards;
- **Confidentiality** – supervision is conducted in a location and manner conducive to candid and uninterrupted discussion.

As the supervisor and supervisee, we agree to:

- Use the Supervision Note during sessions as a “job aid” in facilitating the supervision process and following the supervision model.
- Meet a minimum of one hour every six weeks as well as meeting informally as needed.
- Complete the Supervision Note for every scheduled supervision session.
- Uphold our responsibility to provide feedback to one another on the quality of supervision.
- Bring agenda items to the supervision session.
- Establish goals to be jointly developed
- Ensure that the supervisory relationship is a **collaborative and reciprocal** process through which learning and growth is enhanced and mentoring is accomplished.
- Ensure that the process of supervision reflects building on strengths and assuming competence.
- Respect and show an appreciation for diversity: personal values, belief systems, cultures, differences of opinions, and predispositions.

Date:

Effective until:

Signature of Supervisor: ________________________________

Signature of Supervisee: ________________________________
**Supervision Note**

(Supervisor completes form based upon meeting with practitioner)

Date: _______________ Program: ____________________________

Supervisor: ___________________ Practitioner: ______________________

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<td></td>
<td>Stage (FSP Fidelity and Process Guide)</td>
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<tr>
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<td>FSP/Family relationship</td>
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<td></td>
<td>FSP’s experience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supervisor/Supervisee relationship</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
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<td>Co-ordinating external systemic issues</td>
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<td>Agreed Action Plan</td>
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<td>Issue</td>
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</tr>
<tr>
<td></td>
<td>Stage (FSP Fidelity and Process Guide)</td>
<td></td>
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<td></td>
<td>Current Capacity</td>
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<td>FSP/Family relationship</td>
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<td>FSP’s experience</td>
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### Co-ordinating external systemic issues

**Agreed Action Plan**

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<td>Field Notes</td>
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<td>Evaluation (e.g. EcoMap, Caregiver Strain, etc)</td>
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### Professional Development

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### Ending

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### Feedback

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<td>Feedback</td>
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<tr>
<td></td>
<td>Did you get what you needed?</td>
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</tr>
<tr>
<td></td>
<td>What should we do differently next time?</td>
<td></td>
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<td></td>
<td>What went well?</td>
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**Staff Comments:**

**Additional Notes:**

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<tr>
<td>Yes No</td>
<td>Reviewed by Supervisee</td>
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<tr>
<td></td>
<td>Date Completed</td>
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</tr>
<tr>
<td></td>
<td>Date of Next Supervision</td>
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Appendix 5 - FSP Check List (Family Support Stage Guide)

STAGE 1 – INTAKE

- Family Information Sheet
- Contract for Service
- Confidentiality Forms
- Assent for Evaluation
- Eco Map
- Caregiver Strain
- Safety Plan

STAGE 2 - Family Support Planning and Development

- Eco Map Reviewed and Edited where necessary
- Family Strengths Mapping
- Family Support Plan
- Ongoing confidentiality forms if needed (ie to schools, other community-based resources etc)

STAGE 3 – Moving from Acute Phase to Implementation

- Family Support Plan
- Eco Map Reviewed and Edited where necessary
- How are we doing Questionnaire (administered by evaluation)
- CANS (internal with evaluation)

STAGE 4 – 30 Days (this may need to be modified as first three stages may take longer than anticipated)

- Caregiver Strain Questionnaire
- Family Support Plan
- Eco Map Reviewed and Edited where necessary
- How are we doing questionnaire (administered by evaluation)

STAGE 5 – 60 days (again will likely be modified)

- Family Support Plan
- Eco Map
- How are we doing questionnaire (administered by evaluation)
- CANS (internal by evaluation)

EXIT

- Caregiver Strain Questionnaire
- Eco Map
- Final Family Support Plan – identify some long term goals and supports for families
- How are we doing questionnaire (administered by evaluation)
- CANS (internal by evaluation)
### Appendix 7 – Evaluation Data

#### Caregiver Experience Questionnaire

| Percent of Caregivers who selected Somewhat Agree, Agree or Strongly Agree (n= 23) |
|---|---|---|---|
| **ITEM** | Somewhat Agree | Agree | Strongly Agree |
| When working with the Family Support Provider, I am heard | 0.0 | 9.1 | 90.9 |
| When working with the Family Support Provider, I am understood | 0.0 | 9.5 | 90.5 |
| When working with the Family Support Provider, I am respected | 0.0 | 4.8 | 95.2 |
| The FSP helped us to create a plan that met our family needs | 0.0 | 34.8 | 65.2 |
| The FSP helped advocate for my family | 0.0 | 17.4 | 78.3 |
| I learned new ways to advocate for my family | 0.0 | 17.4 | 82.6 |
| I learned about additional supports and services for my family | 0.0 | 17.4 | 82.6 |
| I learned more about the mental health system | 9.1 | 22.7 | 68.2 |
| I have a sense of hope | 13.0 | 47.8 | 39.1 |
| I feel supported and connected | 9.1 | 27.3 | 63.6 |
| The FSP is knowledgeable | 0.0 | 8.7 | 91.3 |
| My family is getting the support we want from the FSP | 4.3 | 17.4 | 78.3 |
| My family is getting the support we need from the FSP | 0.0 | 17.4 | 82.6 |
| The FSP service is what I expected it would be | 8.7 | 26.1 | 60.9 |
| The times of meetings with my FSP are convenient | 0.0 | 17.4 | 82.6 |
| The locations of meetings with my FSP are convenient | 0.0 | 8.7 | 91.3 |
| I would recommend the FSP service to other families | 0.0 | 4.3 | 95.7 |
| Overall, I am satisfied with the FSP service | 0.0 | 4.3 | 95.7 |

| Percent of Caregivers who selected Somewhat Better, Better or A lot Better (n= 23) |
|---|---|---|---|
| **Item** | Somewhat Better | Better | A lot Better |
| Things as a parent/caregiver are... | 34.8 | 43.5 | 21.7 |
| Things at home are... | 47.8 | 43.5 | 8.7 |
| Things as a family are... | 34.8 | 43.5 | 13.0 |

| Percent of Caregivers who selected Somewhat Helpful, Helpful or Very Helpful (n= 23) |
|---|---|---|
| **Item** | Somewhat Helpful | Helpful | Very Helpful |
| How helpful was the family support plan? | 8.7 | 30.4 | 60.9 |
| How helpful was the eco map? | 9.5 | 47.6 | 38.1 |
## Knowledge of Services Questionnaire

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was more informed about programs I could use</td>
<td>17.4</td>
<td>78.3</td>
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<tr>
<td>I was better able to get help from other organizations and agencies</td>
<td>21.7</td>
<td>73.9</td>
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<tr>
<td>I felt more able to deal with practical problems such as getting my child to the doctor</td>
<td>39.1</td>
<td>39.1</td>
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<tr>
<td>I was more able to meet basic needs such as food and housing</td>
<td>50.0</td>
<td>9.1</td>
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<tr>
<td>I felt more connect with other mothers or people who could help me</td>
<td>63.6</td>
<td>27.3</td>
</tr>
<tr>
<td>I was more connected with programs I could use</td>
<td>30.4</td>
<td>69.6</td>
</tr>
<tr>
<td>I felt more a part of the community where I live</td>
<td>56.5</td>
<td>30.4</td>
</tr>
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## Kinark Staff Experience

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<th>Somewhat Familiar</th>
<th>Familiar</th>
<th>Very Familiar</th>
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<td>How familiar are you with the FSP guiding principles?</td>
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<td>4</td>
<td>2</td>
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<tr>
<td>How familiar are you with the role of the FSP?</td>
<td>2</td>
<td>4</td>
<td>6</td>
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<tr>
<td>How familiar are you with the FSP tools?</td>
<td>3</td>
<td>3</td>
<td>1</td>
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</table>

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
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<tr>
<td>I would likely refer families to the FSP program in the future</td>
<td>3</td>
<td>1</td>
<td>6</td>
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<tr>
<td>I was able to focus more on my clinical work because of the FSP program</td>
<td>2</td>
<td>3</td>
<td>5</td>
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<tr>
<td>I have received enough information about the FSP program</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Family Support is effective for families</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Family Support is effective for children/youth</td>
<td>3</td>
<td>5</td>
<td>3</td>
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<tr>
<td>I support the FSP program</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>My colleagues support the FSP program</td>
<td>2</td>
<td>4</td>
<td>3</td>
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<table>
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<tr>
<th>Item</th>
<th>Stayed the Same</th>
<th>Decreased Slightly</th>
<th>Decreased A lot</th>
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</table>
Because of the FSP, my workload has...

<table>
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<tr>
<th>Number of Kinark Staff who selected Somewhat Satisfied, Satisfied, or Very Satisfied (n= 12)</th>
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<tbody>
<tr>
<td>Item</td>
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<tr>
<td>------</td>
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<tr>
<td>How satisfied are you with how the FSP program is delivered to families?</td>
</tr>
<tr>
<td>Overall, how satisfied are you with the FSP program?</td>
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</table>
May 14, 2013

Tanya Alfieri  
Chapter Leader  
Parents For Children’s Mental Health  
c/o Kinark  Child and Family Services  
34 Simcoe Street Barrie

Dear Ms. Alfieri,

On behalf of the Child and Adolescent Mental Health and Addiction Steering Committee of North Simcoe Muskoka LHIN, I want to thank you for your informative and inspiring presentation at our meeting of April 26, 2013.

You emphasized that families are systems – when one person is affected by a mental health problem, it affects everyone. But more importantly, you shared with us that the experience can be a journey of hope and discovery. With support from the Family Support Provider Program, families can learn new skills and strategies that ultimately make them stronger.

Committee members were struck by the extraordinary impact this kind of support can provide for parents living with a child who is struggling with mental health concerns. We believe that many more families in Simcoe and Muskoka could benefit from the tools and skills you presented. Our hope is that peer support programs for families who have a child living with a mental health concern will not only continue but will be expanded in the future.

Our committee wishes you much success with this pilot program. We look forward to hearing more and if we can support you in any way please let us know.

Sincerely,

Janet Harris,  
Chair, Child & Adolescent Mental Health and Addiction Steering Committee  
North Simcoe Muskoka LHIN Care Connections

cc. Barnabas Walther, Kinark Child & Family Services
## FAMILY SERVICE PROVISION INITIATIVE
### BUDGET 2011-2013

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<th>Total Actual Spent ($)</th>
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<tr>
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