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Organisational Improvement Plan: System of Care

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Abstract

This organisational improvement plan (OIP) describes a way to develop and implement a system of care philosophy within a district school board with the intent of spreading this philosophy throughout the district, province, and country in the future. It is intended to be used as a tool to guide other district school boards interested in implementing a system of care. More specifically, the problem of practice this OIP is intended to address is as follows: "The current model of care for JK-8 students with mental health needs must improve. The service delivery system and pathways to treatment for child and youth mental health in Canada, and in Ontario specifically, are costly, highly fragmented, and difficult to navigate for families and children (Shanley, Reid, & Evans, 2008; Pepler & Bryant, 2011). A system of care, which wraps diverse services around children and families within the communities in which they live, learn, and play, is a better way to meet the needs of children and youth with mental health and other challenges and their families as compared to the current fragmented system (Stroul, Blau & Friedman, 2010).

A readiness to change is a strategic first step to realizing this goal. As such, this OIP explores the leadership capacities necessary to develop, in principals and vice principals within an urban district school board, a readiness for change that will facilitate the development a system of care for child and youth mental health.

This OIP can be generalized to other organisations outside education, including agencies, municipalities, and provincial and national governments. A definition of a system of care is offered along with the accompanying values and principles for system management approaches and principles for service delivery. Development and management of a system of care in a

community involves strengthening relationships with all human service agencies, a change in

system management models, and case management and review, wherein all partners agree to

abide by the definition, values, and principles of a system of care. Assessment with respect to

readiness to change, equity and adherence to system of care structures, values, and principles are

offered, as well as the tools which are to be used initially and at regular intervals at all stages of

development and implementation.

Keywords: system of care, Readiness to change, Principal leadership capacity, Schools,

Children's Mental Health

Acknowledgements

This Organisational Improvement Plan represents the culmination of three years of work within the Graduate Program in Educational Leadership at Western University. It is hoped that this work will help many school systems and communities fully adopt the system of care philosophy. I would like to emphasise that although this OIP advocates a better way to meet the mental health needs of children and youth in Ontario, (as compared to the current system) in no way is it intended to devalue the good work the individuals, groups, organisations and systems currently do. In addition, I acknowledge that there may be other system level approaches that might be as effective or more effective as compared to System of Care, however this is beyond the scope of this OIP.

It has been an extremely difficult and rewarding journey. I am grateful to my wife and four children for their unwavering support. I am also grateful to the eight course instructors of the ten courses in this program for their expertise, passion, guidance, and patience. Thank you to the Associate Dean of Graduate Studies, Dr. Pam Bishop, and Director of the Education Doctorate Program, Dr. Elan Paulson, and the many good people at Western University for crafting a world-class educational experience that will be a model for all institutions of higher learning to follow. Last, but certainly not least, thank you to thesis advisors Drs. Vicki Schwean and Melody Vickzo for your wise counsel, boundless patience, and unwavering confidence in this author. I could not have done it without you! God bless you all!

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Chapter 1: Introduction and Problem

The current model of care for Junior Kindergarten (JK) to Grade 8 students with mental health needs must improve. The service delivery system and pathways to treatment for child and youth mental health in Canada, and in Ontario specifically, are costly, highly fragmented, and difficult to navigate for families and children (Shanley, Reid, & Evans, 2008; Pepler & Bryant, 2011). A system of care is a better way to meet the needs of children and youth with serious mental health challenges and their families as compared to the current fragmented system (Stroul, Blau & Friedman, 2010).

This organisational improvement plan specifically addresses the leadership capacities necessary to develop in principals and vice principals within an urban district school board a readiness for change necessary for implementing a system of care for child and youth mental health. Addressing this problem of practice will be facilitated through focusing specifically on a District School Board (DSB) located in the Province of Ontario. However, the presentation will be equally informative to other learning organisations in other locales.

Principals and vice principals are key change agents in schools (Fullan, 2003, 2014 Eteokleous, 2008, Tondeur et al., 2008). This OIP will introduce strategies intended to determine if principals and vice principals are ready to adopt a system of care. It will achieve this goal by focusing on analyzing the strengths and weaknesses of this group with respect to readiness to change and whether the articulated values of the organisation are consistent with those underlying the system of care philosophy. Lastly, emphasis will be directed toward identifying

potential challenges to the implementation of a system of care and strengths of the organisation which can be capitalized on to introduce, establish, and sustain a system of care.

Organisational Context and Problem of Practice

The following section will discuss why the DSB seeks to implement a system of care. This will involve identifying the pressures that the DSB experiences that have caused it to seek such a solution. Included in this section are some examples of extant data which support the fact that the DSB needs to change to better meet the psychological, social, and behavioral needs of students and families.

The need to achieve a sustainable and effective system of care persists in Ontario, a notion reflected in Ontario Special Needs Strategy (Ontario Ministry of Children and Youth Services et al., 2014). Accordingly, the DSB seeks to achieve this goal to better meet the needs of the children and youth it serves. Currently, the social, emotional, physical, psychological, and intellectual needs of students are not being fully met due to barriers which prevent collaboration between all partners in the community, including schools (Ontario Ministry of Children and Youth Services et al., 2014). Consequently, there is interest in and political will to implement a system of care within the DSB.

Within this DSB, students' needs are varied and the population is diverse, including students with Individualized Education Plans (IEPs); students for whom English is a second language; First Nations, Métis, and Inuit students; students who are recent immigrants; and, students from families with a low socio economic status. These groups of students traditionally have lower Education Quality and Accountability Office (EQAO) results than the "average" population (Ontario Ministry of Education, 2014). An approach based on a system of care

represents an appropriate way to meet student well-being and academic achievement needs in the DSB (Anderson, Butcher & Ashton, 2004), a point that will be further developed later in this proposal.

The consequences for individuals and communities for failing to meet the needs of vulnerable children are dire. Evaluation has demonstrated that the current, fragmented, non-system of care is much less effective in meeting the diverse needs as compared to a system of care (Foster et. al., 2007). The Foster study compared mental health outcomes for children receiving services in two United States (U.S.) federally funded system-of-care communities to those of children in similar U.S. communities but serviced through a traditional, fragmented non-system of care. Children's clinical and functional outcomes over three waves of data collection for 573 children and youth were analyzed. It was found that children at one of the two system-of-care sites showed substantially greater improvement in emotional and behavioural functioning as compared to the non-system of care counterpart. For the other pair, no benefits of the system of care were apparent. The authors of the study concluded that the differences in the effectiveness of the systems of care between the two pairs of sites may reflect differences in system implementation (Foster et. al., 2007).

Two other well-designed studies have shown that the outcomes of system of care interventions have not been superior to outcomes of traditional approaches to providing care (Bickman, Heflinger, Lambert & Summerfelt, 1996; Bickman, Summerfelt, Firth, & Douglas, 1997). This finding has prompted the re-examination of approaches to studying systems of care and led to a focus on process and system level outcomes before moving to a study of child and family outcomes. The mechanism used to establish systems of care, the partner agencies, and the

resulting level of collaboration may be important factors influencing the achievement of client level outcomes (Evans et. al., 2006). It is this extant literature base that informs the current OIP in elucidating on the "how" to successfully and sustainably implements a system of care that will enhance mental health and other outcomes for children and their families. It is clear that a system of care with good process and system level outcomes results in better access and outcomes for youth with mental health needs as compared to the traditional system (Stroul et. al., 2015).

What is a System of Care (SOC)?

A system of care was first proposed in 1986 by Beth Stroul and Robert Friedman as a philosophy to guide service providers to better serve children and adolescents with mental health challenges and their families. Their definition of a system of care was updated in 2015 and serves as the definition for this OIP. "A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organised into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life" (Stroul et.al., 2015, p.3).

The SOC philosophy, for the purposes of this OIP, is intended to help reform child serving systems, services, and supports to better meet the needs of children and youth with mental health and other challenges and their families. The concept has shaped the work of many U.S. states and is beginning to be applied in some Canadian contexts. Indeed, some elements of the system of care philosophy and approach can be located in the DSB policies and practices for meeting the needs of vulnerable children, as well as other regions serving children and youth

with significant mental health challenges and their families. A system of care can and has transformed children's mental health as demonstrated by the good work of the Substance Abuse and Mental Health Services Administration (SAMHSA) in helping many U.S. states adopt a system of care philosophy. Although the literature is mixed in reporting positive outcome benefits for the system of care approach, more recent applications having strong process and system outcomes have demonstrated significant benefits as evidenced by improvements in systems and system access and in the social and emotional functioning of children, youth, and families (Stroul and Friedman, 1986; Stroul et. al. 2015).

The following core values and guiding principles from Stroul, Blau, and Friedman, (2010) must be put into place and maintained to ensure an effective and sustainable system of care. Core values of a system of care encompass:

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided;

2. Community based, with the locus of services, as well as system management, resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level; and,

3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports.

The guiding principles of a system of care are designed to:

1. Ensure availability of and access to a broad, flexible array of effective, evidence-informed, community-based services and supports for children and their families that addresses

their physical, emotional, social, and educational needs, including traditional and non-traditional services as well as informal and natural supports;

2. Provide individualized services in accordance with the unique potential and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family;

3. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate;

4. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their communities, states, territories, tribes, and nation;

5. Ensure cross-system collaboration, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management;

6. Provide care management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and children and their families can move through the system of services in accordance with their changing needs;

7. Provide developmentally appropriate mental health services and supports that promote optimal social and emotional outcomes for young children and their families in their homes and community settings;

8. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult-service system as needed;

9. Incorporate or link with mental health promotion, prevention, and early identification and intervention to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents;

10. Incorporate continuous accountability mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level;

11. Protect the rights of children, youth, and families and promote effective advocacy efforts; and,

12. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status, geography, language, immigration status, or other characteristics; services should be sensitive and responsive to these differences.

It must be stressed that a SOC is a system level approach with a defined set of values and principles. All stakeholders follow the definition, values, and principles to determine how it will work. A system of care involves the utilization of existing community services to support children and youth with mental health challenges and their families. An example of an operational approach that assists a system of care is known as wraparound. Wraparound is a ground level as opposed to system level approach. It is a family driven process for planning and individualizing services for the child and family. It also requires the existence of a flexible pool of money that is shared by multiple child-serving agencies and not tied to each individual service (Kendziora et al., 2001). A given community might decide to use an approach like wraparound to

operationalize the SOC or it may collectively (all stakeholders including families) design an approach that adheres to the values and principles of a SOC that better meets the needs.

The following section will explain about the current system in the DSB and surrounding region and explain why a system of care is a better way to serve children and adolescents with mental health challenges and their families.

Why a System of Care?

A review of the pertinent extant data on the children and families in Ontario who would benefit from a system of care as opposed to the current fragmented "non-system of care" and an examination of the current challenges to children and families receiving services (i.e. fragmented mental health system; lack of specialized educational services, etc.) demonstrates the significant need for change.

> Perhaps the time has never been more appropriate . . . to refocus [our] commitment to children's health and well-being by developing a more robust, family and child-centered service-delivery model that responds directly to need in the most appropriate manner – a model that reaches out to children and families where they live, learn and play, and that focuses attention on prevention and promotion . . . (Watters & Robeson, 1999).

Service delivery. The current system that provides mental health support to children and youth in Ontario is in a state of difficulty (Pepler et. al., 2011). Although the U.S. refers to systems of care, in Canada, we describe it but frequently do not use the same terminology (i.e., systems of care). Furthermore, Schwean and Rodger (2013) challenge us in Canada to be "informed by and draw lessons from the extensive theoretical paradigms, research, and practice base that have defined the children's mental health movement in the United States if we are to achieve significant improvements in access, quality, and efficacy of care for children" in Canada (p. 141). Their statement provides support for the claim that the current service delivery model in

Ontario does not represent a system of care and is currently facing challenges that may be addressed by following the lead of the United States through increasing investment in a system of care to address the needs of children and youth that goes beyond mental health. As a result of the Ontario Government's expressed desire to establish hubs, as documented in the special education strategy (Ontario Ministry of Children and Youth Services et. al., 2014), all partners, including social agencies, medical institutions, the legal system, families, and municipalities in the DSB want to build an effective, affordable, and sustainable system of care model.

The current model in the DSB is a fragmented system best described as a "non-system of care". A 'non-system' of care is where a few children and families get what they need and more, a few do get what they need, while many receive significantly less, if any, of the services they require. Children and families may get lost in this non-system and caregivers, such as principals and vice principals, may not realize they are 'getting lost'. They may not feel it is their responsibility to 'find' them or know how to ensure children and families get the help they need. Even if children and families are 'found', they may refuse to follow a program's rules and be terminated from treatment by staff who believe that they had no other choice (Stein et al., 1990). In some cases, children are moved from the community into a hospital and from the hospital back into the community such that the hospital, the community, the child, and the family all feel mistreated." (Stein et al., 1990).

Cost effectiveness. A system of care is not only is better than the current system with respect to service delivery but also is better with respect to cost effectiveness (Stroul et. al. 2015). The current and previous Governments of Ontario are and have been committed to ensure the costs of services are as low as possible while still maintaining as high a standard of care as

possible. The current system for the provision of mental health services to youth and children in

Ontario is costly for a number of reasons. These include: the fact that more than 400 agencies

(Government of Ontario, 2015) offer help to children and youth with mental health and

addictions concerns and many of these are funded in part by federal, provincial and/or municipal

monies; children and families in need of mental health services must access several different

agencies before receiving service or getting frustrated and dropping out of the system entirely

(Davidson (2011) reports that only 1 in 5 such children and youth in Ontario receive any type of

service); the fact that primary mental health promotion and prevention is not emphasized first

despite this being a better way to reduce the level and extent of need. "The government should

establish additional funds for mental health promotion and prevention and require that they be

used for these purposes only. At a minimum, additional funds should begin at 6.4% of the

children's mental health budget, in line with current public health expenditures" (Office of the

Provincial Advocate for Children and Youth for Ontario, 2012, p. 14).

    The following from the 2008 Report from the Ontario Auditor General further supports

the contentions made in the paragraph above:

> Unlike child welfare and the youth justice system, children's mental health services are
> not mandated by legislation. This lack of mandate has resulted in a hodgepodge of
> uncoordinated services, without a comprehensive plan to provide accessible, responsive
> and effective children's mental health services across the province. Although the majority
> of children's mental health services are funded by the Ministry of Children and Youth
> Services (MCYS), there is a range of hospital-based services that fall under the Ministry
> of Health and Long-term Care and education-based services that fall under the Ministry
> of Education. Services have generally evolved as a result of work done by independent
> transfer payment agencies struggling to meet needs in their own local areas. This
> piecemeal process has resulted in the disparities that currently exist across the province
> and highlight that services have not been developed in a planned and orderly manner
> based on data showing what children actually need (Auditor General of Ontario, 2008).

The Ontario Ministry of Children and Youth Services (2008) and the Children's Health Policy Centre (2000) offers the following which highlights the high costs of the current, fragmented system:

> In the absence of the appropriate form of service and support a young person's needs can increase and impact their developmental trajectory. Ultimately, their untreated or poorly treated mental health needs can have broader impacts that require a more intensive framework of supports that lead to their involvement with child welfare, the youth justice system, and special education services, all of which represents significant additional cost. This does not even factor in costs associated with lost productivity through unemployment for parents and caregivers or for the young person who as an adult continues to grapple with having their service needs met. The estimated lifetime cost for one person with conduct disorder, when no effective prevention or treatment services are offered, is $1.5 million. The total annual cost in Ontario for all mental illnesses and addictions health, including government spending, private spending and lost productivity, is an estimated $39 billion annually.

A system of care clearly results in significant cost savings. Given the fact that system of care is in its infancy in Canada, we have to look to the United States for data on the economic results of a system of care. Stroul et. al., (2014) found the following:

- After 12 months of services in a system of care, 8.6% of youth had dropped out of school, compared with an average of 20% of high school students with mental health challenges nationwide. This result translates into economic gains in average annual earnings and earnings over a lifetime, with an estimated cost savings of 57% per youth.(p.vii)

- From the 6 months prior to intake to the 12-month follow-up, the average cost per child served for inpatient services decreased by 42%. These youth were less likely to visit an emergency room (ER) for behavioral and/or emotional problems, and, as a result, the average cost per child for ER visits decreased by 57%. These youth were also less likely to be arrested, with the average cost per child for juvenile arrests decreasing by 38%. (P. vi)

- After enrolment in a system of care children were: less likely to receive psychiatric inpatient services; less likely to visit an ER for behavioral and/or emotional problems; less likely to be arrested; less likely to repeat a grade or drop out of school (p.28)

- In addition, their caregivers missed fewer days of work due to caring for their children's behavioral and/or emotional problems and had a lower likelihood of being unemployed due to their children's behavioral and/or emotional problems

- After enrollment in a system of care approach using wraparound, overall mental health expenditures decreased by 28%, compared with the pre-enrollment period, and expenditures for out-of-home treatment declined by 44% (Yoe, Ryan, & Bruns, 2011; Maine Department of Health and Human Services, 2011).

- The average cost per family served with the system of care approach using wraparound was 60% less than the cost of those served through the child welfare or juvenile justice system (Baxter, 2013; Nebraska Behavioral Health Services, Region III, 2000; Stroul et al., 2009).

A system of care in the United States is proven to reduce costs compared to the traditional system. In Ontario, the data indicates that costs are high and few child and youth receive the mental health services required in the current system. Children and families in Ontario receiving mental health services experience a fragmented system with a lack of specialized services. This traditional model carries with it a number of conditions that are not conducive to our children and families receiving time sensitive, responsive, and effective (cost and outcome) care (Douglass, 2006). These include:

• Inadequate range of services and supports;

• Lack of individualized services;

• Fragmented system even though children and families have multi-system needs;

• Lack of clear values or principles for the system;

• Lack of clarity about the population of children to be served;

• Inadequate accountability; and,

• Inadequate responsiveness to cultural differences. (Douglass, 2006, p.32).

A system of care model has the potential to address a number of conditions endemic within a traditional mental health system. These include (Stroul et. al., 2015):

- A broad array of services and supports including individualized services;

- A collaborative system featuring one case manager to meet the variety of needs an individual child may have;

- A set of clear values and principles for the system;

- A clear mandate to meet the mental health needs of all children and youth;

- Accountability to the System of Care oversight committee made up of decision makers from each system involved and managed by a system of care manager;

- Responsiveness to cultural and linguistic differences.

As demonstrated above, a system of care is a better way to serve youth and children with mental health needs as from a quality of service, access to service, and cost for service perspective as compared to the current system in Ontario.

Who benefits? Pires and Stroul (2002) argue that a system of care can meet the multiple needs of children and their families. Children who will benefit most include those living in poverty and/or lone parent families, as well as those with mental disorders, disabilities (e.g. chronic health conditions, learning disabilities, speech and language difficulties), and behavioural difficulties (Pires and Stroul, 2002).

In 2007 (the most recent data year available), 11% of the population aged 5 to 24 in Canada lived in low-income circumstances (Statistics Canada, 2009). Children from single-parent families were almost three times as likely (17%) to live in low-income circumstances as children living in two-parent families (6%) (Statistics Canada, 2009). "Children and youth growing up in families of lower socioeconomic status tend to do less well in academic pursuits, are less likely to complete secondary school, and tend to be less successful in entering the labour market than those from more advantaged backgrounds" (Schwean, 2015, p.3). "Education is one of the key routes to lifting individuals out of poverty – but success ultimately depends on situating education and schooling at the heart of a community of care that systemically addresses the economic, social, cultural, and political barriers that children and families in poverty experience" (Schwean, 2015, p.3-4). Surveys (including Waddell, 2001) indicate that anywhere from 14 to 20% of children aged 4 to 17 years have clinically important mental disorders at any given time. This translates to over 800,000 Canadian children who experience mental disorders that cause significant distress and impairment at home, school, and in the community (Waddell, 2001). Unfortunately, only a minority of children requiring mental health services actually receive these services (Bijl et al., 2003). Bijl and others (2003) conducted a cross-national study of disorders and found some of the lowest rates for mental

health treatment in Canada as compared with the United States, the Netherlands, Germany, and Chile.

Moreover, the disability rate for children aged 5 to 14 increased from 4.0% in 2001 to 4.6% in 2006 (Statistics Canada, 2006). The increase in learning disabilities (from 2.6% to 3.2% of school-aged children) accounted for the largest incline but chronic disabilities, psychological disabilities, and speech disabilities all showed an increase of at least 0.3 percentage points (Statistics Canada, 2006). The rate for agility disabilities showed a small increase, although there was no rate change for vision and hearing disabilities (Statistics Canada, 2006). Eighty four percent of parents of school-aged children with disabilities report their children received services from the appropriate health professionals when necessary. For those with unmet needs, speech therapists, child psychologists, and specialized physicians are the health professionals most commonly sought; however, "…child and youth mental health needs are largely unmet, and the system, community, and individual-level barriers to access are well documented…" (Provincial Centre For Excellence, 2010, p. 4). As is the case with young children, for older children, the most common obstacle to seeing a health professional is long waiting lists (Human Resources and Skills Development Canada, 2006, p.12).

Students with behavioural difficulties, mental health needs, and other exceptionalities make up a large proportion of the students not achieving levels three or four in Education Quality Accountability Office (EQAO) testing or proficiency on the Canadian Achievement Test (CAT) 4 (DSB, 2014). It is affirming that some progress is being made overall as evidenced by Ontario's improvement in EQAO testing. For example, EQAO testing undertaken in 2015 reported the following: the percentage of Grade 6 students at or above the provincial standard

had increased by 10 percentage points in reading (from 64 per cent to 74 per cent) and by 12

percentage points in writing (from 61 per cent to 73 per cent); in Grade 3, 73 per cent of students

are meeting or exceeding the provincial standard in writing, up nine percentage points from five

years ago. Results from the assessment of reading skills revealed that 65 per cent of Grade 3

students are now meeting or exceeding the provincial standard; in mathematics, the percentage of

elementary school students achieving the standard in Grade 3 and 6 has remained stable over the

past five years at 69 per cent and 58 per cent, respectively (EQAO, 2015).

Local Data

In the following section, statistics describing the social and economic conditions of

children attending the DSB will be presented. This data has been derived from the 2011

National Household Survey (NHS; 2011 Canadian Census). The data at the school and board

level has been connected to postal code data to reflect school boundaries, resulting in a

demographic profile for the board catchment area. The number of citizens in the board catchment

area is 499,615. The statistics featured in this section help identify the students who are

vulnerable and most likely to require the services and supports provided by a system of care. The

argument will be made that given these findings, a system of care is critical to the well-being of

children within the region.

Low income. Because a system of care wraps services around children and families

within their immediate communities, it provides better access and availability to needed services

and supports (Blau, Friedman and Stroul, 2010). Current care models are typically dispersed

throughout communities and as a result, students and families, particularly those with lower

incomes, have greater difficulty accessing relevant services and supports. Three indicators of low-income from the National Household Survey (NHS) are reported in the overall profile. In the region, 44.65% are in the bottom half of the Canadian income distribution and 8.09% are in the bottom percentage of the Canadian distribution of adjusted after-tax family income. Fifteen percent of DSB families, who are in the bottom half, have children less than 18 years of age. It is these families, in particular, who may benefit most from the availability and access enhancements of services and supports a system of care offers.

Family structure. Approximately fourteen percent of families are lone parent economic families. "Economic family" in the NHS refers to a group of two or more persons who live in the same dwelling and are related to each other by blood, marriage, common-law, adoption, or a foster relationship. The job of single parenting is difficult especially given the extra responsibility that comes with being the only provider (Cummings, Davies, and Campbell, 2000; Pettit, Bates, and Dodge, 1997). Single parents face additional challenges, some of which may cause their children to require greater supports and services. For example, Steinburg (1987) concluded that adolescents from single-parent homes reported greater susceptibility to negative peer influence than those from two-parent homes. In addition, Wallerstein and others (2000) reported that compared with a group of children who had not experienced divorce of their birth parents, the children whose parents divorced indulged in earlier sexual experiences and consumed alcohol and drugs at higher rates. These additional challenges faced by single parents and their children necessitate the need for greater supports and services. With respect to school involvement, quantitative and qualitative studies have shown that, on average, single parents are less frequently involved at school than are other parents (Astone & McLanahan, 1991; Baker and

Stevenson, 1986; Delgado-Gaitan, 1990; Lareau, 1989; Xu and Corno, 1998). Yet, research has

consistently demonstrated that parent involvement at school contributes positively to student

achievement and well-being (Leithwood, 2010). Therefore, greater supports and services are

required to enhance the participation of these children's parents in the schooling of their child.

Lone-parent families represented 16.3 per cent of all census families in 2011 (Statistics

Canada; NHS, 2011). The median income for two-parent families with children was $78,800 and

for single-parent families headed by women, was $38,700 (NHS, 2011). Low socioeconomic

status (SES), single parent status, young parent age, unstable housing, and reliance on

government subsidies are associated with poorer outcomes for children (Lundahl et. al., 2006).

To level the playing field, greater supports and services must be provided for children living in

single parent, low income families.

Mobility. Access to needed services and supports can also be complicated by the

mobility of families, especially those with limited means. In the region, 12.84% of the population

has moved in the past year and 39.42% in the past five years. To address this challenge, one must

have continuity of care so that as a child moves from one health care provider to another,

information obtained by earlier providers will be available to later providers. In Ontario, research

has demonstrated that we still have a fragmented system (Durbin et. al., 2004; Tobon, Reid and

Brown, 2015). Kutcher (2010) argues that, in Ontario, there is really no such thing as a children's

mental health "system". He states, "We have a non-system of non-care" (2011, p. 4.). The

current response to children's mental health needs is made up of a number of separate programs

operated by a wide variety of agencies and organisations across Ontario which is best described

as fragmented and difficult to navigate (Kutcher, 2010).

Other local data. There are other groups of students who require additional support which further stretches DSB resources and helps support the contention that there is a need for a SOC. These figures are similar to those reported by the province of Ontario as a whole (Ontario Ministry of Education, 2013). There are students from 114 countries speaking over 68 different languages which represents significant ethnic and linguistic diversity in the DSB (DSB, 2016b). Three percent of the DSB student population can identify as being First Nations, Metis or Inuit (Education Statutes and Regulations of Ontario, 2016). Seventeen percent of all DSB students receive special education support (DSB, 2016b).

SWOT Analysis

The following Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis represents a research review of the strengths, weaknesses, opportunities, and threats that are involved in a system of care. It was conducted by the DSB Superintendent of Learning using local DSB data from the website and from the websites of a variety of community partners from other systems. This will help identify to all parties the necessary human, physical, and financial resources required to address the needs in the region and how to mobilize and activate these. It also includes resources, partnerships, and growth opportunities which have yet to be accessed. Challenges and obstacles are also identified.

Table 1: Strengths, Weaknesses, Opportunities and Threats associated with a System of Care

Strengths	Threats	Weaknesses	Opportunities
The human, physical, and financial capacity in a community that will be used to build and sustain a system of care.	The lack or lack of engagement of essential human, physical and financial capacity that could be used to build and sustain a system of care.	The unrealized resources, partnerships, and growth opportunities in a community that will enhance and sustain the system of care efforts.	Challenges and obstacles that are present or may present themselves in the process of building a System of Care.
What are the strengths of all our partner Organisations? 1. **Effective communication:** regular, straightforward communication based on trust and clear and simple reporting. 2. **Common values:** a clear understanding of each other's values with mutual commitment to shared goals and responsible behaviour to each other. 3. **Long-term commitment:** this included a commitment to supporting core rather than project costs for partners. 4. **Transparency:** 'clear expectations' was the key concept here, and there was an emphasis on the importance of financial transparency. 5. **Shared learning:** particularly valued was the help with networking and cross-fertilization of good ideas, as well as the sharing of expertise.	What Organisations in the community are not fully participating in the process? Organisations that belong to programs and groups that believe they already work in a system of care. A program that talks and walks the values of a system of care is not necessarily a system of care, it may instead be a strength-based, family-focused outpatient program (Rosenblatt, 2010, p.16). What human resources are we lacking in our community? We are not lacking for human resources, merely the mechanism to bring these resources together to work for a common purpose. What physical limitations do we have? We are not experiencing physical resources merely the mechanism to enable us to share physical resources to achieve a common goal. What do we want to change about our community? We want to truly be able to work together to meet the needs of our most vulnerable children.	Who in our community have we not asked to join our efforts? We need to reach out to ensure all who represent our most vulnerable children are working together in a system of care including those from: agencies and groups who serve children and their families: (Juvenile Justice, Child Welfare, Mental Health, Drug and Alcohol, Education, Physical Health, and Individuals with Developmental Disabilities. What kind of local funding sources have we not considered? All of us have operating budgets and receive and have access to grants. We need to share funding to work to serve our children who are most vulnerable. How can we bring the system of care to more people in our community? We can share resources to expand our reach. What other opportunities do we have? We can assist other communities to develop a system of care and establish links to share services that may not be needed on a regular basis especially by a smaller community.	What could prevent our multiagency partnerships from being successful? A lack of: **Effective communication: Common values, Long-term commitment, Transparency, Shared learning, Contextual awareness, Organisational growth, Participatory processes and Moral support.** Who in our community may oppose the changes brought through a system of care approach? Those who do not want the added complexity of having to work outside of their own agency or group. Those who do not want to share resources, power, influence or recognition. How will our community sustain the program after the initial grant or if there is no initial grant? By sharing budgets and existing and future grants to meet the needs of our most vulnerable children together. What other threats are there to our system of care efforts? Other programs or meeting tables who consider themselves to be doing the same work as a system of care. A program that talks and walks the values of a system of care is not necessarily a system of care, it may instead be a strength-based, family-focused outpatient program. (Rosenblatt, 2010, p.16) A. Rosenblatt / Evaluation and

6. **Contextual awareness:** a deep understanding of the local context and work on the ground. 7. **Organisational growth:** this includes both financial and non-financial support that allows partners to 'scale up' their work. 8. **Participatory processes:** a strong emphasis that the relationship should be a partnership, not a donor-recipient relationship. The importance of sharing processes for monitoring and evaluation was highlighted. 9. **Moral support:** a key factor (both ways) for keeping us motivated. Who do we have involved and what expertise do they bring to the table? The system of care ideally includes leaders from agencies and groups who serve children and their families: (Juvenile Justice, Child Welfare, Mental Health, Drug and Alcohol, Education, Physical Health, and Individuals with Developmental Disabilities.) What physical resources or spaces do we have at our disposal? (potentially) Schools, Grant money and individual budgets and staff.			Program Planning 33 (2010) 14–17

What about our community makes us proud? We already have many 'tables' around which we meet including: Connectivity, The Children's Round Table. What would an outsider to our community say we do well? We do well to get together and discuss issues of mutual concern sometimes acting in concert to address these issues.			

Table 1: Strengths, Weaknesses, Opportunities and Threats associated with a System of Care Adapted from: https://ardhs.sharepointsite.net/ARSOC/Lists/Announcements/Attachments/15/AR%20System%20of%20Care%20Sample%20SW OT%20Analysis.doc.From: http://www.how-matters.org/2011/10/19/measuring-partnership/

Challenges

This section will document what we know to be challenges in implementing a system of care. This has been generated from a review of the literature on system of care, as well as challenges that are specific for the DSB. For the purposes of developing a practical OIP, this section will conclude with a prioritized table that organises the challenges numerically. Unless

individuals, groups, and formal organisations are all willing to make the change in question, it is not likely that it will be successful (Fullan, 2014).

The following sub headings and information (Adapted from Stroul, 2013, p.8) contain a description of some of the challenges associated with implementing a system of care. This is organised first by the most frequent challenges followed by those that are not as frequent. These challenges are based on the experiences of communities which have implemented a system of care approach. Communities seeking to establish a system of care in the future will benefit from these experiences by fully understanding and being prepared for the potential challenges beforehand.

Stakeholder Involvement and Collaboration

- challenging to identify, engage, and prepare youth and young adults to participate;

- difficult to schedule meetings at times that youth and young adults could participate and to provide supports they needed, such as training, transportation, and payment;

- need to identify "youth champions" and provide training and support for their involvement;

- Challenges in engaging families and other caregivers in the planning process and in better developing family voice; transient nature of the target population (U.S. Department of Health and Human Services, 2010, p.27); and,

- Challenges in involving representatives of diverse, multicultural communities in the planning process and acknowledging the need to ensure that their plans address cultural and linguistic competence. "Bringing multiple stakeholders to the table and having all voices heard is always challenging." "It was challenging to get some decision makers to

move beyond 'territory' and 'protecting turf' to collaborative and systematic planning."
(Stroul, 2013, p.9).

Start-Up

- Bureaucratic hurdles for recruiting and hiring staff;

- delays in: gaining approval to accept funds and expend grant dollars, issuing requests for proposals (RFPs), and awarding contracts; and,

- Cumbersome governmental processes and bureaucratic roadblocks.

Time Frame

- One year is too compressed a period to complete a plan of this scope, particularly given the need to identify and engage a wide group of key stakeholders in the process and,

- Grantees stated that "creating a common vision and language takes time," "it took time for the entire team to gel," and "there is insufficient time to engage the entire system effectively."

Planning Process

- Strategic planning is a complex process and can be especially challenging when attempting to involve multiple, diverse stakeholders and perspectives throughout a jurisdiction;

- Understanding the system of care concept in the beginning requires digesting and understanding a tremendous amount of information which may be too consuming for some stakeholders;

- The workload involved in the planning process is challenging for some grantees;

- Stakeholders who are required to take on expansion planning, in addition to their primary jobs, might find it difficult to carve out the time needed to complete the planning activities; and,

- It is challenging to define the steps needed to go from theory to outcomes and from broad discussion and goals to specific, concrete strategies.

Administrative and Fiscal Environment

- Changes in leadership, particularly among policy makers and decision makers, create an unpredictable environment in which changes in direction and priorities are inevitable. It can be difficult for grantees to know whether they will continue to have support for system of care expansion and how to prepare to inform new leaders of the benefits of the system of care approach and

- Uncertain financing poses a particular barrier for grantees in creating a realistic plan. Federal and provincial funding reductions, planning for health reform, and other changes make it difficult for grantees to count on particular sources of funding for services and the infrastructure needed to support systems of care.

Social Marketing

- Confusion about what social marketing plan is required, whether it is intended to be a component of the overall plan or something separate, its goals, what it should include, and its format and

- Guidance to grantees on social marketing must be geared to the community. Lack of experience and expertise in social marketing is a challenge, making it difficult to identify social marketing goals and effective strategies.

Government Requirements and Guidance

- Challenges related to meeting aspects of the requirements for the planning grants.

The following table explains the important components that are necessary for implementation of a system of care (SOC). It is important that these be adhered to throughout the development and maintenance of a SOC, particularly in the early stages. These components express the key values and principles that must be present in a SOC (Stroul, 2013).

Table 2: **Feasibility of Implementation**

Depends On:	• Realistic goals
	• Specific, concrete strategies
	• Initial focus on selected high-priority goals and strategies
	• Initial focus on strategies with high probability of success
	• Strong leaders to manage implementation
	• Commitment to implementation and maintaining active participation among high-level policy makers
	• Common vision across key stakeholders
	• Partnerships across child-serving systems
	• Priority on implementation
	• Allocation of staff and resources to implementation
	• Recognizing accomplishments and the people who contributed to them.
	• Building on existing efforts to avoid duplication and to maximize available resources.

Table 2: Feasibility of Implementation (Adapted from Stroul, 2013, p.ii and U.S. Department of Health and Human Services, 2010, p.26-27).

Implementation challenges were noted by several U.S. states as they implemented a SOC. As this OIP outlines a way for a jurisdiction, these points need to be considered and a way forward developed for each to ensure that a sustainable SOC can be realized.

Implementation Challenges in Order of Priority (Adapted from Stroul, 2013, p. 27, p.34 and U.S. Department of Health and Human Services, 2010, p.26-27).

1. Little or no readiness to change

2. Difficulty in Obtaining Financing

3. Lack of strong and consistent Leaders to Manage Implementation

4. Difficulty in Cross-System Collaboration

5. Difficulty in Family, Youth and associated advocacy group Involvement

6. Lack of Provider Commitment

7. Difficult and Slow Bureaucracy

8. Lack of Political Will

9. Lack of High-Level Commitment

10. Lack of Trained Children's Mental Health Workforce

11. Large Scope of Effort/Difficulty Prioritizing Goals and Strategies

12. Administrative Changes/Unknown Environment

13. Lack of Data to Make the Case for Expansion

14. History of Creating Plans That Are Not Implemented

With respect to challenge 13, measuring a system of care has proven to be quite difficult. "Since systems of care are substantially different in every community, it is difficult to group

them together and measure them all in the same way. Furthermore, most communities have some elements of the philosophy and services, so it is difficult to compare those "with" a system of care to those "without," and traditional research methods have challenges in addressing these complexities" (Stroul et. al., 2010, p. 7). Patton (2008) proposes six conditions that offer challenges to the evaluation of a program, a system, or an organisation: (1) a high level of innovation, (2) ongoing development, (3) high uncertainty, (4) a dynamic situation, (5) emergent phenomena that often result from factors other than careful planning, and (6) systems change. Stroul et al. (2010) confirms that each of these conditions is clearly present in systems of care.

The plan documented in Chapter 3 takes into account and mitigates the effect of these challenges. It is necessary to keep them in mind at all stages of planning, implementation, and maintenance of a system of care so that all stakeholders can work at mitigating or eliminating the barriers.

Readiness to Change

Readiness to change in system of care participants is integral to successful implementation. This section will describe its fundamental importance and include a brief literature review on how school boards can address the issue of readiness to change including examples of some of the strategies that may be employed. As referenced earlier, measuring readiness to change is the first step. Different strategies for senior administration to consider and select from are included in this section. Depending on the results of the tool used to assess readiness to change, a review of the literature to identify different strategies to capitalize on identified strengths and address weaknesses would be required. This could involve using other strategies (e.g., interviews, focus groups, and so on) subsequent to the analysis of the results

from the readiness to change tool to address the problems identified which preclude or impede change.

There are additional barriers which are inherent in schools which will affect the readiness to change to a system of care within the DSB. Although integrating systems of care in schools holds great promise, there are several barriers that have contributed to stalling these efforts: There are varying fragmented program models available to guide these efforts. "Schools have traditionally functioned independently from other agencies and operate under different schedules and structures than other public agencies. Schools usually have few monetary and staff resources and are already under rigorous pressure to produce academic outcomes. Schools thus may be reticent to increase collaborative endeavours if they fear an increase in demands and responsibilities" (Bazelon, 2015). In addition, "…mental health treatment is largely seen by schools as being the realm of social service providers, and school administrators may not want to get involved in these services" (Leaf et. al., 2003).

Support from principals and other formal and informal school leaders is essential for change to occur in schools as it has significant impact on the success or failure of a change (Fullan, 2003, Eteokleous, 2008, Tondeur et al., 2008). In the context of schools, the principal's support is key for change (Fullan, 2014) and, consequently, this OIP will address the readiness to change of principals by paying attention to their attitudes toward change in general and the specific change to a system of care. As creating readiness involves proactive attempts by a change agent to influence the beliefs, attitudes, intentions, and ultimately the behavior of a change target (Armenakis et al., 1993), this OIP will examine if the DSB is ready to implement the change that is demanded by the Ontario Special Needs Strategy (2015). For successful

change to happen within the DSB, principals must believe in the capability of the DSB to change, as well as their own capability to change. Armenakis et al., (1993) have documented the necessity of those who lead change in organisations to demonstrate belief in the organisation's ability to change, as well as having the belief that they themselves can change. Received collective efficacy (an organisational member's assessment of the capability of the organisation to execute specific performances) and perceived self-efficacy (assessment of an individual's own capability) each play an important role in changing organisational culture (Lawson & Ventriss, 1992).

Given that the principal is a key agent of leading change in a school (Fullan, 2014), this OIP will focus on how principals in the DSB consider their readiness to adopt change towards implementing a system of care within their schools. Attributes such as credibility, trustworthiness, sincerity, and expertise must be held by the principal for influence strategies to be effective (Armenakis et al., 1993). The presence or absence of these attributes would have a significant impact on the principals' readiness to change and subsequently, the schools' and board's readiness to change.

The attitude of the principal toward change in general and to the specific change to a system of care is integral. Miller, Johnson, and Grau (1994) argue that, while the failure to successfully implement planned change may be attributed to many factors, few issues are as critical as employees' attitudes toward change. Major organisational change cannot occur without specific groups and individuals changing; that is, without teams and individual employees adopting different work routines or processes and different models, frameworks, or values to guide their actions (Whelan-Berry, 2003). Fullan (2001) suggests that there are seven

core premises with respect to the use of change knowledge, namely: (1) a focus on motivation (identifying as moral purpose); (2) capacity building with a focus on results; (3) learning in context; (4) changing context; (5) a bias for reflective action; (6) tri-level engagement; and, (7) persistence and flexibility in staying the course.

The process of change described above and change knowledge are related. Change agents must possess change knowledge to manage the process of change. For example, with respect to successfully raising awareness and affecting emotions (two processes identified by Prochaska, 2001), one must develop the knowledge and competencies in themselves, as well as in others to make this happen. A leader must be aware of the individuals and groups involved in the change and know (by using change knowledge) when to apply pressure and when to back off to provide more support. For example, a leader must have knowledge about capacity building, which includes any strategy that increases the collective efficacy of a group in creating a desired change (Fullan, 2007), such as the implementation of a system of care.

Fullan (2001) reminds us that motivation and engagement are the keys. If the given reason for the change and the expressed outcomes do not motivate people and drive them to individual and collective action, improvement is not possible (Fullan, 2001). Fullan (2001) goes on to note that moral purpose is a great initial motivator but must be accompanied by conditions that enable several key aspects of motivation— capacity, resources, peer and leadership support, and identity, to name a few. Capacity building with a focus on results captures aspects of good leadership, including pressure and support (Fullan, 2007). Capacity building ultimately involves developing knowledge and competencies, resources, and motivation among individuals and groups (Fullan, 2007). These capacities are specifically about achieving results (e.g.

implementing a system of care). Fullan (2007) goes on to note that most theories of change are weak on capacity building and that is one of the key reasons they fall short.

A leader must also have change knowledge regarding accountability to implement the stages of change. No external accountability scheme can be successful in the absence of internal accountability, the latter being defined as capacity building with a focus on results (Elmore, 2004). Accountability must not be the sole focus. Resources for capacity building must accompany accountability to make the process of change seem fair and reasonable to those experiencing the change (Fullan, 2007). Fullan (2007) highlights that motivation increases if results are focused on fairness (e.g. comparing like schools, using data over multiple years, providing targeted support for improvement). His change theory dictates that capacity building comes first followed by judgment of reasons for poor performance. Capacity building with a focus on results is thus enhanced, resulting in better chances for sustainable change.

Fullan's third basic premise is that strategies for reform must build in many opportunities for 'learning in context'. In a system of care, for example, all partners must be aware that "we are all learning as we go". Elmore (2004) supports this notion of contextual learning, "Improvement is more a function of learning to do the right things in the settings where you work" (p.73).

He notes that for change to be successful, all partners must have opportunities for engaging in continuous and sustained learning about their practice in the settings in which they actually work. "Cultures do not change by mandate; they change by the specific displacement of existing norms, structures, and processes by others; the process of cultural change depends

fundamentally on modeling the new values and behavior that you expect to displace the existing ones" (Elmore, 2004, p.11).

For example, if one of the desired changes is to have organisational transparency, the leader must manage the change process with transparency and always act accordingly in all interactions. Change agents must adapt how they apply change knowledge about capacity to different contexts as an identical approach in a different context may yield different results with respect to the degree to which a change is adopted and sustained. Different individuals and groups in the same organisation may require different approaches with respect to intensity and time depending on the knowledge and skills they possess at the time.

Fullan's (2007) fourth basic premise is that theories of action must also have the capacity to change the larger context. Fullan's theory of action proposes that moral purpose, coherence making, relationship building, knowledge creation, and sharing, each promoted with enthusiasm, energy, and hope, leads to internal and external commitment which results in greater movement toward the desired change. In the case of education, the idea of tri-level reform comes into play. The school, district, and province must all be able to affect one another. Fullan (2007) explains that when this happens, best practices and ideas are exchanged back and forth. People identify with larger and smaller parts of the system and are therefore motivated as they feel part of a larger whole (school to district or district to province for example). As a result, they are connected to the grassroots (province to district or district to school for example). Fullan (2007) warns that this exposes partners to a plethora of initiatives which increases the danger of distraction. As a result, efforts must be in place to keep the main focus of change the single goal that all levels of tri-reform work towards.

Tri level reform involves the school and community, board of education, and province. Fullan (2005) reminds us that aligning these is not possible. He uses the term 'permeable connectivity' (p.11), which he describes as pursuing strategies that promote mutual interaction and influence within and across the three levels. The idea is that if enough leaders engage in 'permeable connectivity', the system itself will change. (Fullan, 2005). Furthermore, all levels must interact. For example, learning for teachers (the first level) must be supported by all levels in the education system. It is not the sole responsibility of the individual teacher, nor is it solely the responsibility of the board or province. Complex problems cannot be solved from a distance; the steady growth of the power to manage change at all levels by having all levels interact must be part of the solution (Fullan, 1992).

To implement a system of care in the DSB, attention must be directed toward capacity building and development. Capacity development requires change. The implementation and management of this change from a non-system of care to a system of care is a huge and complex task. As a result, attention must be paid to all components of change in the academic and business aspects of the DSB. The agents of the change to a system of care (especially principals) must understand how important change is to the success of the implementation of a system of care at all levels, as the changes necessary for implementation to a system of care affect many elements and individuals within the DSB and the surrounding community and in turn, how they relate to each other.

The change agents (especially principals) must understand if and to what extent all partners are ready. If the change to a system of care is initiated without assessing readiness, it could result in wasted opportunities and resources and may even cause damage to existing

capacity. In addition, because all parts in the DSB are interrelated, many may be ready, but one small part could block the move to a system of care from being effective. The ability of principals, especially to manage change, which includes communication skills, flexibility, responsiveness, and strategic thinking, for example, is paramount. If the right conditions are not put into place, capacity creation, utilization, and retention may be compromised, resulting in unsuccessful implementation. Change leaders within the DSB must understand what the potential 'roadblocks' are. Knowing the nature and extent of the challenges can provide valuable guidance as to how or how not to proceed. In some cases, the challenge may have to be dealt with first in order to proceed. In other cases, it is possible that the best course of action would be to modify the entry point to by-pass a challenge that can't be solved.

Summary

As discussed above, principals and vice principals are key change agents in schools (Fullan, 2003, 2014 Eteokleous, 2008, Tondeur et. al., 2008). The DSB will use this OIP in the near future to find out if principals and vice principals are ready to change and adopt a system of care to better serve students and families. Chapter 3 will describe the tool that is best for the DSB to discover the extent to which principals and vice principals are ready to change. It will also feature a method of analysis of the strengths and weaknesses of this group with respect to readiness to change and next steps to capitalize on the strengths and address the weaknesses so a system of care can be introduced, established, and sustained. In Chapters 2 and 3, this will be expanded upon and a comprehensive plan for organisational change will be explained. Additional strategies and tools will be required to respond to the results of the readiness to

change tool as discussed above. As such, Chapter 2 will focus on providing a deeper look at other possible theories, tools, and solutions for leading change.

Chapter 2: Planning and Development

Theories of Organisational Change

Cawsey et. al., (2015) propose a model for change involving five core concepts: initial organisation analysis, why change, gap analysis, action planning and implementation, and measuring the change. These do not directly correspond to Fullan's (2007) seven core premises of change, but there are similarities. The following five paragraphs are a summary of Figure 11.1 "A Summary Model of Organisational Change" (Cawsey et al., 2015, p.376). The model will be instructive in helping the DSB change from a non-system of care to a system of care.

The first concept involves unfreezing (Lewin, 1947) the system, a concept that requires a clear delineation of "how" to change and "what" needs to change. Within works such as Stroul and Blau (2008), The System of Care Handbook, the "what" is well documented. For example, one must "increase awareness of the system of care concept and philosophy among current and future mental health professionals who provide services to children, youth and their families; broaden the mental health field's understanding of treatment and services delivery beyond traditional approaches to include innovative, state of the art approaches and evidence based practices; and provide practical information that will assist the mental health field to implement and apply the philosophy, services, and approaches embodied in the system of care concept" (p.x). Cawsey, Deszca, Ingols, and Fullan help with the "how". Cawsey et al. (2015) suggest that energy must be applied to shake an organisation out of its complacency (e.g., a fragmented, non-system of care) as the natural preference is for equilibrium (no change). The authors go on

to explain that the change leaders have to have a clear organisational frame work to use for analysis.

The second concept is about figuring out the need for change, anticipating the kind of change that might occur at various levels and establishing the change vision. These include ensuring that the perception of the need for change is created and understood by all and are willing to ensure that a convincing vision for change is spread. This change vision is contrasted with a description of the present state followed by a gap analysis. Therefore, in the following section, the current non-system of care is contrasted with the preferred future of a system of care.

The gap analysis includes a fulsome description of the current state of service delivery and an explanation of why the vision of a system of care presents a more preferable alternative. Formal systems and structure, the informal organisation, change recipients, and change agents are all subjects of analysis. Readiness to change would be assessed using the School Readiness to Change Self - Assessment. The System of Care Practice Review (SOCPR) would be applied to the DSB to determine, explore, and document the degree to which service and support planning and delivery to students and families is consistent with system of care values and its approach to care.

The gap analysis is followed by action planning and implementation. There are five steps identified within this core concept. The first is the development of the activity plan which includes: contingency planning for all anticipated roadblocks and a process for dealing with the unanticipated; communications planning to ensure all stakeholders are informed at all stages; steps for managing the transition to the new vision (the change); and, celebration and review after each action. The use of Fullan (2007) and Cawsey et. al. (2015) works along with those

such as Stroul and Blau (2008) will help in implementing this gap analysis. The gap analysis would also include remediation steps to address the readiness to change gaps and a plan of how to capitalize on the readiness to change strengths revealed by the school readiness to change self-assessment. This is a formal tool which assists schools in examining their readiness to implement change with a critical eye toward self-reflection. The instrument identifies activities, processes, and collaborations that, when present, lay the foundation blocks for implementing significant and meaningful change in a school, which in this case is the change to a system of care. Similarly, remediation steps would be implemented to address areas which were revealed to be inconsistent with system of care values and its approach to care, and a plan would be made to continue strengthening aspects consistent with these principles. .

The last core concept consists of measuring the change and designing effective control systems. This includes measurement of the change over time and continued monitoring and response to ensure the change is systematically incorporated throughout the system. Finally, the change to a system of care from a non-system of care will be evaluated. A useful tool to achieve this end would be the Rating Tool for Implementation of the System of Care Approach for Children, Youth, and Young Adults with Mental Health Challenges and their Families (Stroul et. al., 2015).

Comparison of the Two Models

A brief comparison of Fullan's (2007) seven core premises of change and the five core concepts of change from Cawsey et al. (2015) illustrates strong alignment. Fullan's (2007) notions of moral purpose and capacity building with a focus on results can be viewed as

somewhat equivalent to Cawsey et al. (2015) unfreezing, as in both instances a power shift must

happen to convince stakeholders (especially change leaders) that a change is needed. Fullan's

(2007) learning in context and a change in context is equivalent with Cawsey et. al. (2015)

articulation of the current state (context) and analysis of the choices available to stakeholders

with respect to changing (or not). Fullan's (2007) reflexive action and tri-level engagement can

be equated to the fourth core concept of action planning and implementation (Cawsey, Deszca,

and Ingols, 2015). The gap analysis helps determine the reflexive action and engagement

required at all levels. Fullan's (2007) tri-level model is specific to education and refers to the

school, district, and state or provincial levels. The theory could also apply to organisations where

diverse stakeholders are at varying levels of change readiness – particularly those who are

external. Fullan's conceptualization of persistence and flexibility in staying the course (2007) is

not as comprehensive as Cawsey et al. (2015) last core concept of measuring the change over

time and continued monitoring and response.

Type of Organisational Change

The current fragmented way in which youth with mental health needs are cared for

constitutes a performance crisis which requires a reactive change that involves implementing

systems of care. Nadler and Tushman (1989), in addressing the issue of organisational change,

argue that a reactive change is a response to a significant performance crisis. The development of

a system of care is the reactive change, and the current fragmented, non-system of care is the

performance crisis. A discontinuous and radical change is one that involves: re-evaluation of the

whole organisation, including its core values; a focus on all organisational components to

achieve rapid, system-wide change; and, involvement by senior management to create vision and motivate optimism (Nadler and Tushman, 1989).

In moving to the adoption of a system of care philosophy, the DSB must be re-evaluated as it is part of the fragmented, non-system of care in Ontario which does not align with its mission of being "heart of the community where there is success for each and a place for all" (DSB, 2016). Moreover, it does not align with our vision of "nurturing hope in all learners so that they can transform God's world" (DSB, 2016). All organisational components must be involved, and senior management must create vision and motivate optimism especially within principals and vice principals who are the key agents of change (Fullan, 2007).

Organisational Analysis of the DSB

The DSB has a long history dating back to 1836. It currently has 46 elementary schools, five secondary schools, two adult education facilities, and a day school enrolment of approximately 20,000 students. The Board has a diverse student population, representing over 114 countries and more than 68 languages (DSB, 2016b). With respect to the School Effectiveness Framework Indicator 2.3 (i.e. organisational structures are coherent, flexible and respond to the needs of students), the DSB strives to ensure:

At the school:

- The learning environment is intentionally organised to optimize learning time.
- Timetabling is strategic and facilitates learning for all students and the appropriate allocation of human and other resources.
- The allocation of human and other resources is responsive to changing student needs.

- (Elementary) Sustained uninterrupted blocks of learning time are used daily for literacy and numeracy.

- The budget process is transparent and reflects school priorities in the School Improvement Plan.

- Communication and procedures support student learning during all transitions.

- Teams meet regularly for the purpose of supporting learning for students, including those who are not meeting subject/course requirements and/or learning expectations in the Individual Education Plan.

In the classroom:

- The learning environment is both intellectually challenging and developmentally appropriate for all students and organised to optimize teaching and learning.

- Student advocacy is taught and welcomed.

Students:

- Advocate for conditions that support their learning.

- Work in flexible and varied groupings according to the learning task and their learning needs (DSB, 2016c).

The DSB is structured as follows (Figure 2). It is imperative that these stakeholders have full opportunities to become aware of the need for change and be actively involved in the implementation of a system of care within the DSB.

Table 3: DSB Organisational Structure
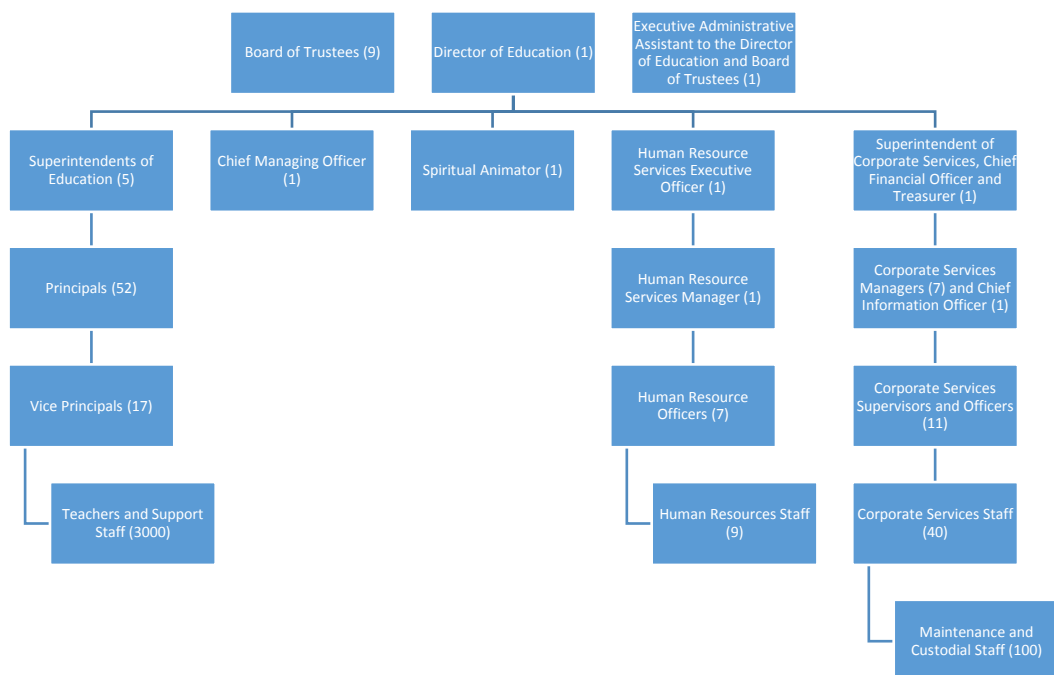
Table 2: DSB Organisational Structure

External Environment

The external environment of the DSB (local region) is largely representative of the situation in Ontario in that there is a fragmented, non-system of care in place. There are, however, a couple of groups which represent greater alignment to system of care values and principles. These are *Connectivity* and the *Children's Planning Table*.

> "Connectivity is the name of the Region's "Situation Tables", which bring health and social service agencies together at a weekly meeting to collaboratively and proactively address situations of elevated risk. Connectivity is based on a Community Mobilization Hub Model originating in Prince Albert, Saskatchewan. The model is a multi-disciplinary, interagency approach to addressing situations of acutely elevated risk on a case-by-case basis. The approach enables organisations to be immediately responsive to acute needs in the community" (Brown and Newberry, 2015, p.8).

> "The Children's Planning Table is a collaborative of service providers, planning bodies and funders who have come together to plan how services can be better coordinated for children in the Region. The mandate of the Children's Planning Table is to serve as an integrated planning table for children's services from pre-birth to 12 years of age in the Region. The Children's Planning Table serves as the Region's Best Start Network. This planning table will take on the role of developing an Early Years Community Plan over the next few years. The Children's Planning Table's vision is that all children in the Region live in a community that supports their developmental health through a system of coordinated and effective services. All organisations providing support services to children (pre-birth to 12 years of age) are considered stakeholders at the planning table" (Region Community Services, 2016).

Aligning with these groups in a significant way will be essential to engaging community partners in the development of a school board wide, and eventually a regional, system of care philosophy.

The System of Care Practice Review (SOCPR) is "a method of measurement used to explore and document the degree to which service and support planning and delivery is consistent with system of care values and its approach to care" (Hernandez, Worthington, and Davis, 2005, p.2). This tool would be used to measure the Connectivity and Children's Planning Tables to assess how their philosophy and practices are consistent with system of care values and approaches to care. It would also be applied to how the DSB serves students and their families.

The Organisational History and Culture of the DSB

The DSB is a publicly funded school system consisting of 51 schools serving approximately 40 000 students from pre-school age to adult in the Region.

The need to achieve a sustainable and effective model for a system of care persists in Ontario, a notion reflected in Ontario Special Needs Strategy (Ontario Ministry of Children and Youth Services et al., 2014). Accordingly, the DSB wants to achieve a sustainable and effective model for a system of care. The social, emotional, physical, psychological, and intellectual

needs of students are not being fully met due to barriers which prevent collaboration between all partners in the community in the schools (Ontario Ministry of Children and Youth Services et al., 2014). Consequently, there is interest in and political will to implement a system of care within this mid-size Canadian District School Board.

As mentioned earlier, there are particular groups of students (e.g. students with IEPs, students who use English as a second language, recent immigrants, First Nation Metis or Inuit students, students from single parent and/or low socio-economic families, students who are LGBTQ) which demonstrate the diversity of needs in the DSB. These groups of students traditionally have lower EQAO results than the "average" population (Ontario Ministry of Education, 2014). As a result, the DSB is interested in implementing a system of care to better meet the needs of these vulnerable populations of students. An approach based on a system of care represents an appropriate way to meet student well-being and academic achievement needs in a way than the current "difficult to navigate, highly fragmented system "cannot (Anderson, Butcher & Ashton, 2004).

Framing the Problem of Practice (PoP)

Review of pp. 317---320 of the Bolman & Deal (2004) text identifies specific frames (Figure 3) to match the DSB's PoP. The PoP is as follows: "The current model of care for JK-8 students with mental health needs must improve. The service delivery system and pathways to treatment for child and youth mental health in Canada, and in Ontario specifically, are costly, highly fragmented, and difficult to navigate for families and children (Shanley, Reid, & Evans, 2008; Pepler & Bryant, 2011). A system of care is a better way to meet the needs of children and

youth with serious mental health challenges and their families as compared to the current

fragmented system (Stroul, Blau & Friedman, 2010).

There are leadership capacities necessary to develop in principals and vice principals

within an urban district school board to create a readiness for change to a system of care for child

and youth mental health. Individual commitment and motivation is essential to the success of a

system of care. In particular, the principal at each school is integral to the success of the change,

as the principal has been identified as the key change agent in a school. Support from principals

and other individual formal and informal school leaders is essential for change to occur in

schools; indeed, this support or lack thereof will have a significant impact on the success or

failure of systemic change (Fullan, 2003b, Eteokleous, 2008, Tondeur et al., 2008).

The following table, derived from the works of Bolman and Deal (2004), identifies four

distinctive 'frames' from which people view their world - Structural, Human Resources,

Political, and Symbolic. Each frame comes with a range of concepts, metaphors, and values

which provide the scaffolding for organising a view of the current situation. In the case of this

OIP, the four frames model is useful to help organise the process for change as described in

greater detail below the table.

Table 4: Bolman and Deal (2004, p.18) Four Frames Model Overview

	Structural Frame	Human Resource Frame	Political Frame	Symbolic Frame
Metaphor for organisation	Factory or machine.	Family.	Jungle.	Carnival, temple, theatre.
Central concepts	Rules, roles, goals, policies, technology, environment.	Needs, skills, relationships.	Power, conflict, competition, organisational politics.	Culture, meaning, metaphor, ritual, ceremony, stories, heroes.
Image of leadership	Social architecture.	Empowerment.	Advocacy and political savvy.	Inspiration.
Basic leadership challenge	Attune structure to task, technology, and environment.	Align organisational and human needs.	Develop agenda and power base.	Create faith, beauty, and meaning.

Table 3: Bolman and Deal (2004, p.18) Four Frames Model Overview

In the context of schools, the principal's support is key for change (Fullan, 2014) and, consequently, this organisational improvement plan (OIP) will direct the organisation to assess readiness to change of principals by paying attention to their attitudes toward change in general and the specific change to a system of care. In assessing the readiness for change in the DSB, the readiness of stakeholders beyond principals will also need to be considered in the near future. The human resource and symbolic frames are highly relevant, as the principal must empower stakeholders and align organisational and human needs to inspire and create meaning or as Fullan (2007) argues, identify a 'moral purpose'. The structural and political frames are less relevant as the roles, rules, goals, and policies in a school are well established and understood and the power structure is also well defined.

The technical quality of the decision to move to a system of care is important. There is data supporting the superiority of a system of care versus the current fragmented system (Douglass, 2006; Evans et. al., 2007; Patton, 2008). This data is strong when the values and principles of a system of care are strongly in place as determined by using a tool such as the SOC-PR but there is little or no difference as compared to the traditional system when they are not. The conceptual and structural framework for implementing a system of care has also been clearly delineated in previous research and practice and as such, provides the DSB with a "roadmap" for identifying the rules, roles, goals, policies, technology, and environment necessary for developing and implementing a system of care (Stroul and Blau, 2008). Even though the process for change is well documented (Cawsey, Deszca, and Ingols, 2015; Fullan, 2007), implementing the system within new environments will not inoculate against political coalitions or members holding on symbolically to what is familiar. As a result, change agents,

including principals, vice-principals, and senior administration, must be vigilant, articulate, and effective in dealing with resistance and conflict as they occur throughout the change process. Conflict and scarce resources are likely to be quite significant as various partners in a system of care must work together and share resources more than in the current non-system of care (Stroul and Blau, 2008) where independence of agencies is the norm. The political and symbolic frames will be represented in actions such as advocacy, political savvy and inspiration to help address conflict, scarce resources, and independence of agencies.

The structural frame. The DSB has faltered, especially with respect to its structural frame, in recent years. These deficiencies must be addressed before a system of care can be successfully implemented. Since 2012, the DSB has essentially been without a working multi-year strategic plan (MYSP) due to frequent changes in leadership (e.g., six different directors to date). This has had a significant detrimental impact on the DSB, as it has resulted in each senior leader acting within their own portfolios with little effort directed toward tying the efforts and effects of each senior leader together in a cohesive whole and working toward common goals. The structural frame illuminates this issue of having six different directors and no MYSP as there has not been clarity in terms of role expectations and regular, organised, clear communication between senior leaders. Each one has tried to implement a new MYSP to little effect given that none of them has been present long enough for the changes to take effect. Strategy is, of course, strongly connected to structural change. As the articulation of the strategy varied with each director, the implementation of the MYSP failed. The most recent director has just spearheaded an effort to develop a new MYSP which has been in effect since December 1, 2015. This has

involved all stakeholders and promises to be quite effective in addressing these structural issues, as members of the DSB now have a clearly articulated set of goals and strategies to follow.

With respect to the structural frame, the DSB must incorporate more decentralization and interactive lateral forms to increase the initiative and creativity of our very talented and passionate workforce (Bolman and Deal, 2013, p.59). Initiative and creativity is the very essence of a system of care and will go a long way toward its successful establishment. All partners must be able to work together on a level playing field to successfully address the adaptive problems a system of care philosophy can efficiently address (e.g., addressing the complex needs of struggling students and families).

The human resource frame. Since June, the director of education of the DSB has also been developing relationships effectively and presented the new strategic plan (as mentioned above) with assurances, this director will be here for at least five years. This is closely connected to the political frame, as it is crucial to build coalitions to implement the new strategic plan. With respect to the Human Resource frame, the change in leadership direction has resulted in cautious optimism and planned change is beginning to occur as a result. It is anticipated that the successful design and implementation of the MYSP will enhance the development of a coordinated system of care, particularly given that the system of care philosophy is deeply ingrained in the goals and strategies of the new MYSP.

Prior to the recruitment of the current director and presentation of a MYSP, some employees were unwilling to follow directives from above (which hampered the implementation of the MYSP). There are a number of possible explanations for this including considerable change in senior administration from outside the Board (i.e. hiring principals from other boards

to be supervisory officers) and union and management issues. There have also been challenges with hiring at the senior level. In the past, some employees have felt oppressed or neglected if they felt they were not favoured by senior management, resulting in them withdrawing from work. Our improved situation will assist in the development and implementation of a system of care as employees are more willing to follow directives when there is greater stability in the organisation, any appearance of cronyism and nepotism has been addressed, and clear goals and strategies have been expressed for all in the MYSP.

Distributed leadership, staff development, and being attentive to employee needs have been approached differently by each Director which has created confusion. For example, there has been duplication in of efforts and other issues which had not been addressed due to not having an MYSP with common goals and clear strategies. Employees were not working toward organisational goals because of a lack of clarity as to whether a given directive from an individual senior leader was actually a common goal of the organisation or just a "pet project" of an individual senior leader. The clear goals and strategies of the MYSP have addressed these issues, paving the way for successful implementation of change in the form of the adoption of a system of care philosophy.

The political frame. As noted above, the DSB has a new leader who has been developing relationships effectively and presented a new strategic plan with assurances she will be here for at least five years. This point is connected to the political frame, as it is necessary to build coalitions to implement the new strategic plan. The political problem that existed within the DSB is that the trustees were heavily involved in operations, which is contrary to the DSB model of governance. This could be viewed as a structural problem of overlapping

responsibilities which has been addressed by the new director who reviewed mandated governance procedures with board members. For example, trustees had been actively involved in directing teachers and principals, which creates confusion. This is no longer the case as proper governance is being followed. The teachers, superintendents, managers, and principals now know whose direction to follow as the MYSP is followed by all. The competing coalitions within the DSB with competing priorities exercising power and trying to 'win' are now working together using the MYSP. To address these issues, the MYSP has provided a clear set of goals and strategies including who is responsible for decision-making and implementation. The director (the only employee of the board of trustees) is beholden to the trustees and must walk a line between pleasing the trustees and adhering to the governance model. As mentioned above, this is a structural concern which has been addressed. It is also political as the director has found ways to successfully align the trustees in navigating sometimes incompatible preferences. The trustees have tried in the past to exercise direct authority over superintendents, principals, vice principals, and teachers instead of placing oversight responsibility with the director to implement policies.   The current director has used an authoritative approach to remind the trustees of their governance role and move them "out of the kitchen". It appears, at this point, that this approach has worked, as trustees are not contacting staff directly as they did in the past. Interventions undertaken by the director will greatly support the implementation of a system of care as trustees are asked to establish policy to support this philosophy and employees are charged with carrying this out.

      The symbolic frame. Early signs indicate that the vision inherent in the MYSP (which aligns with the philosophy of a system of care-described below) and inspiration provided by the

new director is taking hold as staff have articulated a renewed hope that many of the problems

that have plagued the DSB in the past have been addressed. People are beginning to believe this

director is here 'for the long haul'. This has gone a long way toward ensuring changes articulated

in the MYSP are taking hold in a sustainable way which connects strongly to the symbolic

frame.

As Cawsey et al., (2012) remind us, "…organisations are everywhere. Organisations are

how we get things done" (p. 2). Bolman and Deal (2004) contend that organisations exist to

serve people (Bolman and Deal, 2004). This is not always the case. Some organisations (and

formal leaders) seem to operate as if people exist to serve organisations. When an organisation

leaves a given country to move to another to pay its employees significantly less so as to

maximize profits, one seriously questions Bolman and Deal's contention that organisations "exist

to support people". The organisation in this case is actually "exploiting its people" in the interest

of profit. By and large, it is clear that the DSB exists to serve people, most notably its students,

as stated in the mission - "We nurture hope in all learners that they will realize their potential to

transform God's world" (DSB, 2016). The way the DSB is understood by its employees is

changing. However, there still are times when it appears that the DSB exists (or behaves as if it

exists) for people to serve it. For example, sometimes a decision is made to save money (such as

cutting educational assistants) that clearly is not beneficial to staff, students or families.

A system of care is an organisational philosophy that is clearly superior to the current

fragmented non-system of care. Some resistance is to be expected as the initial move to a system

of care will put a strain on resources in the short term (Stroul and Blau, 2008). It is anticipated

that the change will be successful as most of the time, the DSB operates in a way that

demonstrates that the organisation indeed exists to serve people. Implementing a system of care is clearly a better way to serve people, one that conceptually and philosophically will hopefully be supported by all who strongly subscribe to the mission of the DSB.

      How choices and decisions are shaped by the board. Choices and decisions of senior management are shaped by the mission of the DSB. Senior management is able, for example, to incorporate faith and values as practicing Roman Catholics into all decisions. Leaders are able to use the teachings from the bible and guidance from the Church to help determine how to best respond to conflict. As the DSB is a publicly funded system, leaders are also expected to follow the education act as written by the Ontario government. This sometimes creates conflict as the secular government does not always agree with the Church. Recently, the advent of gay straight alliances and the implementation of some aspects of the new Health and Physical Education Curriculum presented some dualities to senior leaders. As leaders whose choices and decisions are shaped by the DSB, the 'both/and' needs to be considered; that is, decisions that are acceptable to both the Church and the Government need to be arrived at. With respect to implementation of a system of care within the DSB, the Ontario Government (Fullan's third level with respect to tri-level educational change) does advocate the use of a hub model in the Special Education Strategy but does not use the concept of system of care anywhere. This may create similar tensions to those described above and will necessitate the need to clearly identify complementarities between these frameworks.

      Takeaways. The first and most important takeaway involves developing an in-depth knowledge of organisational theory and change theory. In particular, the summary of organisational change models presented by Cawsey, Deszca, and Ingols' (2012) is helpful in

developing an OIP. The second takeaway involves developing capacity to use theory as an

analytical tool help frame the problem of practice (PoP), assess the organisational climate of the

DSB, and determine if change is necessary. Bolman and Deal's (2004) four frames model is

useful in analysing the PoP as described above. The third takeaway involves raising awareness of

beliefs about organisations and change processes. In particular, it is often taken for granted that

organisations behave in ways that indicate that they exist to serve people. In reality, senior

leaders are often more aware that sometimes, organisations act in ways that make one believe

that people exist to serve the organisation.

Networked Improvement Community (NIC)

As demonstrated by the DSB's participation in Connectivity and the Children's Planning

Table, the DSB is beginning to demonstrate the potential of school to school and school to

community collaborations. As is the case with many organisations, the DSB is moving from a

system that has largely operated independently in a very fragmented way and been resistant to

collaborating with its community partners to one that embraces meaningful and authentic

collaborations across all sectors. This idea is supported by Allen and Cherrey (2000):

> Two major shifts occurring in the world are having a significant effect on how we
> work together, influence change and lead our organisations. The first shift is from a world
> of fragmentation to one of connectivity and integrated networks. The second shift is from
> an industrial to a knowledge era…….All of us need to explore new ways of working that
> keep pace with this networked knowledge era (Allen & Cherrey, 2000).

One strategy for effecting connectivity and integrated networks within communities is

through implementing a Networked Improvement Community (NIC). A NIC involves learning

in context. In the case of the DSB, the context is that of an Ontario School Board implementing a

system of care. As demonstrated in this OIP, the learning that must happen is quite specific to the

context of the DSB. This learning must include understanding both internal and external

strengths and weaknesses, as revealed by the results of the assessment tools which will be

applied. The goal is to expand this context beyond the DSB throughout the whole community.

Fullan explains it this way:

> When you learn in context two things happen. One is that, by definition, the
> learning is specific to the context. The other is that you are doing so with
> others… The very premise of systems thinking is that you continually expand the
> contexts which you experience and learn from as you seek solutions to complex
> adaptive challenges. Learning in wider contexts leads to changing these very contexts as
> one interacts with others to develop new solutions. (Fullan, 2005a).

Schools are familiar with professional learning communities within their walls. A

networked improvement community is indeed a networked learning community, as one must

learn in order to improve. The OECD Lisbon Seminar (2003) defines Networked Learning

Communities as follows:

> Networked Learning Communities are purposefully-led social entities that are
> characterised by a commitment to quality, rigour and a focus on outcomes…. They
> promote the dissemination of good practice, enhance the professional development of
> teachers, support capacity-building in schools, mediate between centralised and
> decentralised structures, and assist in the process of re-structuring and re-culturing
> educational organisational systems.

This organisational improvement plan starts with implementing a system of care

philosophy in principle within the DSB. From there, it will be necessary to move across levels

into the community and the province. Michael Fullan (2005b) describes this lateral expansion in

this way:

> When you enlarge your world laterally within your own level of the system, and
> vertically across levels, you gain ideas and perspective. When many people do this you
> literally change the very context (for the better) within which you work. Networks get
> you out of your own narrow world. In sum, I believe we should push ahead with
> networked learning communities. One route to strengthening networked learning
> communities is to have a growing number of leaders exploiting the strategy for the

greater public good. The question it leaves us with is how can we now build on early initiatives to accomplish the greater ownership, coherence, capacity and impact which systemic change beyond the plateau demands of us all?

By assessing readiness to change, assessing the presence of the values and principles of a system of care, conducting an equity audit, and subsequently, capitalizing on the documented strengths and addressing the weaknesses, the OIP will help principals operate as a NIC to achieve the greater public good that results from a SOC (i.e., initiatives which lead to greater ownership, coherence, capacity and impact).

Steps to Bring Principals to the Point Where They Are Champions for a System of Care

Preliminary work will include using The School Readiness to Change Self - Assessment, which is a:

> …comprehensive, voluntary instrument designed to assist schools in examining their readiness to implement change with a critical eye toward self - reflection. The instrument identifies activities, processes, and collaborations that lay the foundation blocks for implementing significant and meaningful change in a school. A central premise of this self - assessment is that all schools have strengths upon which to build and, through ongoing reflection, can identify existing effective features and practices and use them as cornerstones for promoting broad - based change. Another premise is that schools can learn from each other by sharing information on what constitutes readiness to implement change—both from the standpoint of what currently supports change and what can be done in the future to advance schools' readiness to implement change (Measurement Incorporated, 2014).

In addition, the System of Care Practice Review (SOCPR) will be used. This tool is "a method of measurement used to explore and document the degree to which service and support planning and delivery is consistent with system of care values and its approach to care" (Hernandez, Worthington and Davis, 2005, p.2). This tool would be used to measure the DSB to assess how consistent it is with system of care values and its approach to care. Based on the information provided by these tools, actions will be taken to strengthen weaknesses and

capitalize on strengths with respect to both readiness to change and consistency with system of care values and approaches to care of students and families. These steps are based on Fullan's (2007) seven core premises for change: a focus on motivation (identified as moral purpose); capacity building with a focus on results; learning in context; changing context; a bias for reflective action; tri-level engagement; and, persistence and flexibility in staying the course.

The first step is to get all of the DSB principals and vice principals together to begin the process of articulating a shared vision of developing a system of care. As this is a substantive goal, it is anticipated that it would take several meetings to accomplish. This will involve building awareness and need for a system of care that aligns with current definitions and contemporary research: "A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organised into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life" (Stroul et. al., 2015, p. 3).

In articulating this definition of system of care, the moral purpose (Fullan, 2007) will be established. The state of the current system will be shared, as will arguments for why a system of care is the best way to go forward if the DSB seeks to fully support the needs of children and families.

The second step will be to share with principals their responsibilities in building capacity with their entire school staff. This will involve repetition of the moral purpose exercise with teachers, support staff, and parents. Capacity building would involve responding to the data generated by both the readiness to change and system of care practice review and planning for

and enacting subsequent action. This step necessitates learning in context and working together to change the context. Principals would be asked to model reflective action as each step is taken in response to the measurement tool results. Reflective action is simply examining action and learning from it to replicate that which is effective and improve what proves not to be. Tri- level engagement would involve implementing the System of Care Advisory Committee. When the principals have demonstrated that they believe in and are able to articulate the definition, values, and principles of a SOC, they would begin working closely with the larger community. The school alone cannot generate a system of care – it must work closely and collaboratively with all partners. Persistence and flexibility would be modelled by the principals throughout. A subsequent step would be to establish a system of care advisory committee to oversee this work. The following terms of reference briefly explains this committee.

Board System of Care Advisory Committee Terms of Reference

This committee will advise the director and superintendents regarding the development of a system of care. A principal or vice-principal will chair it as they are a key agent of change in schools as per Fullan (2007) and Leithwood (2010). In the initial stages it will be necessary to meet every three weeks as per the Superintendent of Learning but this may be changed by the committee to monthly or every six weeks as needs dictate. The responsibilities documented in table 5 will be assumed by sub-committees appointed by this committee. The advisory committee will do the preparatory work, will appoint sub-committees to carry out the work and will continue as an oversight committee once the SOC is established. The committee reports to the Director of Education who also approved its establishment.

Purpose/mandate. To develop a future vision for a system of care in the DSB and larger region utilizing the following services: mental health, social, educational, health, substance abuse, vocational, recreational and operational.

To lead a community engagement process that gathers input to be used by the partners to help inform long-term decision-making and priority setting for the system of care.

Tasks. 1. To develop a future vision for the provision of services in the DSB, as part of a larger regional system of care.

2. To oversee a constructive and robust community engagement process to inform this future vision and help ensure the final proposed solution best meets local community, child, and family needs.

Membership. Mental health, social, educational, health, substance abuse, vocational, recreational and operational services.

Reporting relationship. A principal will be appointed as Chair, as the principal has been identified as the key change agent in the school community. When the principals have demonstrated that they believe in and are able to articulate the definition, values, and principles of a SOC, they would begin working closely with the larger community. The school alone cannot generate a system of care – it must work closely and collaboratively with all partners.

Meeting frequency. Every 3 weeks or at the call of the Chair until completion of the community engagement process and vision for the future.

Responsibility. This committee would be responsible for ensuring that the system of care approach adopted is designed to: (from Stroul, B., Blau, G., & Friedman, R., 2010)

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational and physical needs, including traditional and non-traditional services as well as natural and informal supports.

2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.

3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.

4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.

5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, province, and country. .

6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.

7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children

and their families can move through the system of services in accordance with their changing needs.

8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.

9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.

10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.

11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.

12. Protect the rights of children and families and promote effective advocacy efforts.

13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and services should be sensitive and responsive to these difference.

In addition, the committee would need to: (Adapted from: Mental Health Vermont, 2014)

- Promote an ongoing priority to make family members and youthful partners in the development and implementation of policies and programs that affect them. Make a strong commitment to continue development and implementation of Integrated Family Services (IFS) across the region, including consolidation of formerly segregated funding streams.

- Coordination beyond IFS: Explore system-wide coordination of IFS across all partners and their respective departments.

- Ensure appropriate peer support is available for families and youth, including funding for paid peer navigation assistance from family-run organisations for those with complex challenges.

Chapter 2 has focused on planning and development. In the move to developing and implementing a system of care philosophy, a leadership framework for understanding change has been documented in keeping with the works of Fullan; Cawsey, Deszca and Ingols; and, Bolman and Deal. Findings from these authors were analyzed and information and data gathered to select the best change path for the district school board and surrounding community. Chapter 3 will focus on taking this knowledge and document how best to use it to implement, evaluate and communicate further tools and strategies for effecting and monitoring the change to a system of care.

Chapter 3: Implementation, Evaluation, and Communication

Tools and Strategies for Monitoring the Change to a System of Care

This chapter describes the implementation plan for developing a system of care within the DSB, which includes setting the stage for implementation in the region. Included is a plan for monitoring and evaluation, as well as a communications plan. The following points from Stroul and Friedman (2013) serve as a checklist highlighting the activities which must occur. Although some of these are beyond the scope of the initial implementation within the DSB, it is important that principals and vice principals be exposed to all aspects of development so as to develop a comprehensive picture from initial school and Board implementation to full community implementation.

These topics will serve as the material in the various training sessions for Board and school staff, as documented later in this chapter.

Strategic Organisation: Implementing Policy, Regulatory, and Partnership Changes

(Adapted from Stroul and Friedman, 2013).

The following figure outlines the activities and actions necessary for a variety of stakeholders to undertake in the move to adopting a system of care philosophy. These are organised using a change management organizing system known as Awareness, Desire, Knowledge, Ability and Reinforcement (ADKAR) (ADKAR Change Management. (2016).

Table 5: Building a System of Care

Vision: Our preferred future is where all children and families in the DSB can access coordinated services that contribute to their social, emotional, linguistic, educational, cultural, and economic development within their community. We are working with the Region to create a Region in which people, organisations and systems with different strengths and perspectives work together more effectively for the safety and well-being of children and families.

Mission: To make effective, coordinated, culturally and linguistically competent, community-based support available for children, youth and families throughout the school board and in the larger community and through this assistance help them to function better at home, in school, in the community, and throughout life.

Beliefs: If services for our students are family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided, outcomes of service will be more positive as compared to the current system.

If services for our students are community based, with the focal point of services, as well as system management, resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level then students in need will be more likely to receive and benefit from needed service compared to the current system.

If services for our students are culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations students and families will better be able to access and utilize of needed services as compared to the current system.

The following chart is organised using a goal-oriented change management model (ADKAR).The five parts of ADKAR (awareness, desire, knowledge, ability and reinforcement) show the milestones that must be achieved for change to be successful ("ADKAR Change Management", 2016).

Strategic Priority	Strategic Activity	Stakeholder Involvement	Tasks/Actions (to achieve goals)	Evidence/Monitoring Responsibility Of…	Timeline Year 1, 2 or 3		
Awareness (of the need for change)	To develop understanding of what a system of care is.	Administrators (principals and vice-principals), managers and senior leaders understand what a system of care is	Train 5 of the most senior administrators (one from each family of schools) to understand what a system of care is in a series of 3 sessions (session 1- definition, session 2 – values, session 3 – principles) and pass this knowledge on.	Superintendent of Learning using a "ticket out the door" (3 questions) for each session to ensure understanding of the basic values and principles of a SOC.	X		
			Work with these 4 administrators to introduce the definition, values and principles of a system of care to their peers and superiors using the same approach as they experienced	As above.	X		
	DSB staff, students, parents and families understand what a system of care is	Employees parents, students and families	Managers and administrators to introduce the definition, values and principles of a system of care to help all understand what a system of care is in a series of 3 sessions (session 1- definition, session 2 – values, session 3 – principles)	Managers and principals will administer an on-line survey to determine understanding of what a system of care is consisting of 10 questions.	X		

					X		
	Service providers associated with the school understand what a system of care is	Employees parents, students and families	Managers and administrators to introduce the definition, values and principles of a system of care to help all understand what a system of care is in a series of 3 sessions (session 1- definition, session 2 – values, session 3 – principles)	Managers and principals will administer an on-line survey to determine understanding.	X		
Desire (to make the change happen)	Senior management, principals and vice principals	To further develop the team of 4 administrators to help their peers and superiors understand the current system and why a system of care is a superior alternative	Train these 4 administrators to understand the current system and why a system of care is a superior alternative	Superintendent of Learning using a "ticket out the door" for each session to ensure understanding.	X		
			Work with these 4 administrators to develop understanding in their peers and superiors of the current system and why a system of care is a superior alternative using the same approach as they experienced	Superintendent of Learning using a "ticket out the door" for each session to ensure understanding	X		
	Understand the current system and why a system of care is a superior alternative.	Employees, parents, students and families.	For managers and administrators to help all understand the current system and why a system of care is a superior alternative	Managers and principals will administer an on-line survey.	X		
	Understand the current system and why a system of care is a superior alternative	Service providers.	For managers and administrators to help all understand the current system and why a system of care is a superior alternative	Managers and principals will administer an on-line.	X		
Knowledge (about how to change)	For principals and vice principals to be enabled to lead change to a system of care	For principals and vice principals to develop the knowledge of how to change	To develop a deep understanding of Fullan's (2007) seven core premises of change and the five core concepts of change from Cawsey, Deszca and Ingols (2015) in a five session series.	An assessment of learning conducting by the respective superintendent of each school family to ensure understanding of Fullan's (2007)		X	

				seven core premises of change and the five core concepts of change from Cawsey, Deszca and Ingols (2015)			
		For principals and vice principals to develop the knowledge of how to perform effectively in a system of care.	To develop a deep understanding of how to perform in a system of care by studying works such as the Toolkit for Expanding the System of Care Approach and The System of Care Handbook	Monitored by the Superintendent of Learning using a "ticket out the door" for each session.		X	
Ability to change (by developing new skills, structures and habits)	Establishing an organisational locus of SOC management and accountability at DSB, local, and eventually provincial levels (consistent with Fullan's (2007) tri-level support.	Principals, Vice-Principals, local service providers and eventually provincial ministries	A committee consisting of the superintendent of learning, executive council and principals and vice principals and local service provider representatives will be established for the purpose of: • Developing and implementing strategic plans between the school board, principals and vice-principals and local services providers and eventually provincial ministries • Developing interagency structures, agreements, and partnerships for coordination and financing • Promulgating rules, regulations, guidelines, standards, and practice protocols • Incorporating the SOC approach as requirements in requests for proposals and contracts • Enacting legislation at the Board, Municipality and Provincial levels that supports the SOC approach • Incorporating the SOC approach in protocols to monitor compliance with SOC requirements • Incorporating the SOC approach into data systems for	Superintendent of Learning, Executive Council			X

			outcome measurement and quality improvement • Linking with and building on other system change initiatives (e.g., health reform, parity legislation, reforms in other systems) • Expanding family and youth involvement at the policy level • Improving cultural and linguistic competence at the policy level and incorporating strategies to eliminate disparities				
	Developme nt and Expansion of Services and Supports Based on the SOC Philosophy and Approach	Principals, Vice-Principals, local service providers and eventually provincial ministries	A committee consisting of the superintendent of learning, executive council, principals and vice principals and local service provider representatives will be established for the purpose of: • Creating or expanding the array of home- and community-based services and supports • Creating or expanding an individualized, wraparound approach to service delivery (building on the aspects of The Children's Planning and Connectivity Tables that are consistent with a system of care) • Creating care management entities • Creating or expanding care coordination and care management • Implementing family-driven, youth-guided services and expanding family and youth involvement at the service delivery level • Creating, expanding, or changing the provider network with new providers and by retooling and aligning community and residential providers • Creating or expanding the use of evidence-informed and promising practices and	Superintendent of Learning, Executive Council			X

			practice-based evidence approaches • Improving the cultural and linguistic competence of services • Reducing racial, ethnic, and geographic disparities in service delivery • Implementing or expanding the use of technology (e.g., electronic medical records, telemedicine, videoconferencing, e-therapy)				
	Creating and Improving Financing Strategies	Principals, Vice-Principals, local service providers and eventually provincial ministries	A committee consisting of the superintendent of learning, executive council, principals and vice principals and local service provider representatives will be established for the purpose of: • Increasing the use of OHIP to cover all required services, especially for families with economic challenges • Increasing the use of Mental Health Grants, federal and provincial SOC grants, and other federal and provincial grants • Redeploying funds from higher-cost to lower-cost services • Implementing case rates or other risk-based financing approaches • Increasing the use of federal and provincial mental health and substance use funds as applicable • Increasing the use of funds from other child-serving systems • Increasing the use of local funds • Increasing the use of provincial and federal entitlements other than OHIP for example • Accessing new financing structures and funding streams	Superintendent of Learning, Executive Council			X

			(e.g., health reform, parity legislation)				
Reinforcement of the change (sharing of data and student and family stories about the effect of SOC)	Establishment of a baseline measure regarding the efficacy of the current fragmented system	Principals, Vice-Principals, local service providers and eventually provincial ministries	A committee consisting of the superintendent of learning, executive council, principals and vice principals and local service provider representatives will be established for the purpose of: using the equity and the system of care evaluation tools and gather student and family stories to determine the baseline level of efficacy of the current fragmented system	Superintendent of Learning, Executive Council	X	X	
	Regular measurement of the effects of the developing system of care (of application of the SOC values and principles and assessing if there is an increase in the number of children and youth accessing mental health care)	Principals, Vice-Principals, local service providers and eventually provincial ministries	A committee consisting of the superintendent of learning, executive council, principals and vice principals and local service provider representatives will be established for the purpose of: using the equity and the system of care evaluation tools and gather student and family stories to determine the level of efficacy of the developing system of care compared to the baseline results from the former fragmented system	Superintendent of Learning, Executive Council			X
	Communication of the measurement results	Media, School Board Stakeholders, Service Providers, Region Students, Families and Residents, All levels of government	A committee consisting of the superintendent of learning, executive council, principals and vice principals and local service provider representatives will be established for the purpose of: communicating the equity and the system of care evaluation tools and student and family stories which determine the level of efficacy of the developing system of care compared to the baseline	Superintendent of Learning, Executive Council			X

			results from the former fragmented system				

Table 4: Building a System of Care

Data Gathering Process

After offering informational sessions to various in-house and external groups to introduce the concept of and need for a system of care (as documented in Table 6), assessing the readiness for change and willingness to adopt a system of care (SOC), as well as conducting an equity audit at both the school board and later the community level, represents the next set of tasks that must be undertaken. It is necessary to measure three areas to help determine the work that needs to be done to successfully implement a system of care. The following descriptions are adapted from The Family Run Executive Director Leadership Association, (FREDLA) 2014).

Assessing readiness to change. The following tool associated with readiness to change provides structured and customized strategies for understanding, planning, communicating, and implementing a desired change in the organisation. This change is characterized in the problem of practice as documented earlier, namely that the current model of care for youth and children with mental health needs can be improved and that a system of care is a better alternative. What leadership capacities are necessary to develop in principals and vice principals within an urban district school board to create a readiness for change to a system of care for child and youth mental health?

The following tools - The School Readiness to Change Self - Assessment (Measurement Incorporated, 2014), The Rating Tool for Implementation of the System of Care Approach (Stroul et. al., 2015), and The *Reflective Tool for School and System Leaders (Ontario Ministry of Education, 2014b)* have been selected based on a review of the organisational and system of care literature, as well as a thorough understanding of the DSB..

     Tool description. The School Readiness to Change Self - Assessment Tool assists schools in examining their readiness to implement change with a critical eye toward self-reflection. "The instrument identifies activities, processes, and collaborations that, when present, lay the foundation blocks for implementing significant and meaningful change in schools, which, in this case, is the change to a system of care as expressed in the PoP above. A central idea of this self - assessment is that all schools have strengths upon which to build and, through ongoing reflection, can identify existing effective features and practices and use them as cornerstones for promoting broad - based change. Another strategy for promoting learning across schools involves sharing information on what constitutes readiness to implement change—both from the standpoint of what currently supports change and what can be done in the future to advance schools' readiness to implement change" (Measurement Incorporated, 2014).

     Rationale for tool selection. The School Readiness to Change Self - Assessment is structured around Quality Indicators— a comprehensive framework developed through an in - depth, collaborative process involving an extensive review of the literature on school change and related fields and feedback from schools. Although the indicators encompass some of the key elements of a school's readiness to undertake change, they go beyond by capturing what might be considered an ideal or model framework for understanding change readiness. Altogether, 47 quality indicators are included in the instrument. They address five areas of school readiness to change: Relevance and Meaning, Consensus and Ownership, Scope and Culture, Structure and Coherence, Focus, Attention and Letting Go. Also included are examples of evidence (i.e. "look - fors") that school staff can use to determine whether or not the quality indicators are in place. It should be noted that high quality education is a moving target, and continuous improvement can

only be maintained if practitioners continue to examine what they are doing, explore creative

strategies, and share their knowledge and experience.

For the purpose of this organisational improvement plan for the DSB, The School

Readiness to Change Self - Assessment (SRCSA) has been chosen. As the implementation and

sustainability of a system of care is an ongoing process given the variety of needs of students and

families, schools must continually engage in self-reflection to ensure they are meeting their

needs.

The DSB has focused on a strengths based approach toward learning for all. Each

individual school within the system has similarities and differences. Schools provide examples to

other schools and learn from each other. Each principal, for example, is encouraged to work to

make not only 'their school' better but also other schools and the system as a whole. A central

premise of the SRCSA is that all schools have strengths upon which to build and, through

ongoing participant reflection, can identify existing effective features and practices and use them

as cornerstones for promoting broad - based change. Another premise is that schools can learn

from each other by sharing information on what constitutes readiness to implement change—

both from the standpoint of what currently supports change and what can be done in the future to

advance schools' readiness to implement change.

Limitations of the tool. This tool was designed to assess readiness for changes in special

education programs in New York State schools. As a result, it may be limited due to the

differences in the education systems of New York and Ontario. It also may be limited in that it is

designed to measure a change in special education programming as opposed to treatment for

child and youth mental health. However, after carefully examining the tool in light of the

possible limitations, it was found that any differences in the New York State and the Ontario education systems did not render any of the questions any less effective. In a similar way, because mental health is often part of special education in Ontario, this difference in populations assessed was not determined to be a significant issue. It is important though to continue to consider these possible limitations as the DSB moves forward in its implementation of the system of care.

Assessing the implementation of a system of care. The Rating Tool for Implementation of the System of Care Approach (Stroul et al., 2015) provides structured and customized strategies for understanding, planning, communicating, and implementing a desired change in the DSB. This tool has been selected based on the context of the DSB and the leadership within that organisation.

Tool description. The Rating Tool for Implementation of the System of Care Approach (Stroul et. al., 2015) is designed to assess progress in a geographic area, typically a community or region, in implementing the system of care approach for children, youth, and young adults with mental health challenges and their families.

In addition to assessing the level of system of care implementation, the information gathered can inform the nature of technical assistance aimed at efforts to improve systems of care. This tool is designed to provide a "snapshot" of the implementation of key elements of the system of care approach at a point in time. Use of this instrument in the DSB will enable specification of the particular types of change required to move the system of care development forward.

Rationale for tool selection. The tool offers a method for deriving an estimate of the "level" of implementation of the system of care approach. Ratings estimate system of care implementation at one of five levels: No Implementation; Some Implementation; Moderate Implementation; Substantial Implementation; and, Extensive Implementation. As a result, the information realized from this tool can be examined in concert with the information from the readiness to change tool to determine the best way to move forward. This tool has been used across the United States for initial assessments when efforts are underway to develop the system of care. It can also be used to improve the system of care at later stages of implementation. The tool will be used in initial development and at regular intervals to assess progress over time. Specifically, it will be used annually to determine progress and identify areas needing attention while implementing the system of care approach. The Rating Tool can also be utilized in the broader community when the system of care approach has migrated beyond the school and board level to assess progress throughout the Region in implementing the system of care approach. The Region can use the tool to obtain a baseline rating and subsequent ratings of progress that are tied to their efforts to implement, sustain, and expand the approach across the region in accordance with the structure of their service systems in a similar way that schools and DSB applied it initially. The Region can then determine the percent of its communities that have achieved each of the five levels of implementation of the system of care approach. Repeated use of the tool annually for the Region (and perhaps the province in the future) can provide a measure of progress based on comparisons of the percent of communities or regions at each level of implementation over time. Further, the average ratings on each element across communities

provide a method for identifying the need for selective investment of resources and technical assistance.

Limitations of the tool. This tool was designed for a broader community rather than within a school district. As many community agencies serve schools, it is difficult to isolate schools from the broader community. As a result, it may be difficult to fully utilize and respond to the results until the broader implementation of the system of care definition, values, and principles occurs in the larger context.

Other reflections. Realizing the broad and specific values, principles, and goals of a system of care will be difficult to fully accomplish until there is broader adoption in the larger community. The promising news is that the Region is already demonstrating a number of the values and principles (given the existence of the Children's Planning Table and Connectivity Tables, for example) even given the current fragmented system. With a collective and collaborative focus on improving the areas of deficit in the community, positive outcomes within schools will also be enhanced.

Tool description. The Reflective Tool for School and System Leaders, a resource provided by the Ontario Ministry of Education, 2014b) is designed to support school and system leaders in their ongoing reflection on how to strengthen implementation of Ontario's equity and inclusive education strategy in schools and boards. Equity is a key part of the values and principles of a system of care. The 8 key areas of focus within the tool are:

1. board policies, programs, guidelines, and practices (incorporating the principles of equity and inclusive education (EIE) into all aspects of its operations, structures, policies, programs, procedures, guidelines, and practices);

2. shared and committed leadership (effective leadership to improve student achievement and to close achievement gaps for students by identifying, addressing, and removing all forms of discrimination;

3. school-community relationships (establishing and maintaining partnerships with diverse communities so that the perspectives and experiences of all students are recognized and their needs are met (2014b);

4. inclusive curriculum and assessment practices (implementing an inclusive curriculum and reviewing resources, instruction, and assessment and evaluation practices to identify and address discriminatory biases and maximize students' learning potential (2014b);

5. religious accommodation (acknowledge each individual's right to follow or not follow religious beliefs and practices free from discriminatory or harassing behaviour and committed to adhering to the board's religious accommodation guidelines (2014b);

6. school climate and the prevention of discrimination and harassment (every person within the school community is entitled to a respectful, positive school climate and learning environment, free from all forms of discrimination and harassment (2014a));

7. professional learning (every person within the school community is entitled to a respectful, positive school climate and learning environment, free from all forms of discrimination and harassment (2014b); and,

8. accountability and transparency, (assessing and monitoring their progress in implementing an equity and inclusive education policy; to embedding the principles into all board/school policies, programs, guidelines, and practices; and to communicating these results to the community (2014b).

Rationale for tool selection. This resource has been, and will continue to be, used to engage students, staff, and communities in reflecting on the eight areas of focus that support the identification and elimination of barriers to student achievement and well-being at all levels. This is clearly expressed in the values and principles of a system of care. School and system leaders in the Board will be asked to review the guiding principles presented above, the legislative and policy contexts, the updated Equity and Inclusive Education Guidelines (2014a), and Policy/Program Memorandum No. 119 (2013), as well as the prohibited grounds identified in the Ontario Human Rights Code, before responding to the questions for reflection outlined in the Tool.

Limitations of the tool. This tool is a self-assessment and as such, is subject to bias in that respondents may answer questions to appear as they want themselves and their school to be rather than as they actually are.

Other reflections. Generally, individuals think they think and act in ways that are fair and equitable. The problem is that most teachers and administrators generally do not experience inequity themselves. Teachers and administrators are often white, relatively affluent, and well-educated. As a result, very few are or have ever been marginalized. The work before progressive educational leaders is to build awareness that our society is often unjust and inequitable, teach them to recognize those individuals who are marginalized, and then help and assist them in developing the knowledge and skills to address these inequities in a sustainable way.

Leadership Development Strategy

The first goal of the MYSP of the DSB engages school and system leaders as transformational leaders to build capacity for instructional leadership, enhance organisational

effectiveness, build relationships, and support succession planning. The second and third goals respond to our moral imperative which is to reach every student as per the renewed vision for Education in Ontario. These goals, of course, have the development of a system of care philosophy at their core. Our school and system leaders will respond to the needs of our students predicated on the view that every student has the inalienable right to learn, progress, and achieve. It is anticipated that the DSB will support the goals in a variety of ways from distinct leadership modules to mentoring sessions with new and experienced leaders. By adopting a multi-faceted approach, the DSB expects not only a broadening resourcefulness for the current generation of leaders but also for the generations who follow, thereby ensuring sustainability and effective succession planning.

The DSB has recently adopted a leadership approach that will be facilitative of the implementation of a system of care. Philosophical tenets that have been adopted (e.g. create and promote leadership opportunities and enhancement of leadership capacity, further develop capacity to respond to the needs of learners and families) and strategies (e.g. innovation in leadership, training for new administrators, advanced training for experienced administrators) will aid in developing the awareness, desire, knowledge, and ability to needed to develop and maintain and care system. The DSB also has administrative structures that will support the development of a system of care and provide leadership to emerging initiatives within (e.g., special education department personnel such as social workers). The table below documents how the DSB leadership approach will facilitate the development of a system of care.

Table 6: The DSB Leadership approach to system of care development (adapted from DSB, (2016d).

"Overall Goal: To develop leadership capacity to support the achievement of goals outlined in the Multi-Year Strategic Plan and the Board Improvement Plan for Student Achievement including the development of a system of care within the DSB.

Goal One: Create and promote leadership opportunities that engage all school and system leaders in order to strengthen staff capacity for instructional and spiritual leadership, to enhance organisational effectiveness, to implement a system of care and to support succession planning as defined by research including Strong Districts and their Leadership and the Catholic Leadership Framework.

Goal Two: School and system leaders in the DSB will develop the capacity to appropriately respond to the needs of learners by fostering a holistic view of student learning that encourages shepherd, servant and steward leadership within a system of care.

Goal Three: Create and provide opportunities for enhancing leadership capacity for the entire system by engaging in active professional lifelong learning, faith formation, and mentorship and coaching including learning specific to implementing a system of care. By adopting a multi-faceted approach, we anticipate that we will broaden the resourcefulness of all our staff, the current generation of leaders and the generations to follow thus ensuring sustainability and effective succession planning. With an emphasis on strengthening network improvement communities (NIC) across all levels of leadership to better serve the system."

Strategic Priority	Strategic Activity	Stakeholder Involvement	Tasks/Actions (to achieve goals)	Evidence/Monitoring Responsibility Of…	Timeline 16-17	17-18	18-19
Awareness (of the need for change)	Review learning from the awareness activities Figure 1.				X		
Desire (to make the change happen)	Review learning from the desire activities Figure 1.				X		
Knowledge (about how to change)	The BLDS Steering Committee will coordinate activities and opportunities for learning based on the Catholic Leadership Framework and the System of Care Handbook with respect to the four strategies (innovation in leadership, training for new administrators, advanced training for experienced administrators)	DSB Board Leadership Development (BLDS) Steering Committee	Supply Coverage =$2000 Ongoing with seven meetings during the school year Support Resources = $1000 BLDS Manual Catholic Leadership Framework SEF DEF BIPSA Strategic Directions System of Care Handbook	DSB Board Leadership Development (BLDS) Steering Committee Indicators of Success of the Leadership Development Program 1. Qualitative Data from module feedback through the SO entrance and exit interviews with each school and system leader. 2. Module Surveys 3. Principal Performance Appraisal (PPA) reports will		X	

Ability to change (by developing new skills, structures and habits)	Embracing of theory and application of change management in the examination of innovative leadership practices in the areas of setting directions, building relationships and ensuring accountability.	Innovation in Leadership for all administrators	Guest Speakers Computer Simulation License Fees Resources $15 000 Brochure outlining the Leadership Strategy and Brochure Outlining System of Care Catholic Leadership Framework Entrance/Exit Conferences Pope Francis: Why He Leads The Way He Leads (hardcover) Modules one to six. System of Care Handbook	demonstrate increased capacity in areas defined by goals. 4. BIPSA monitoring will demonstrate achievement aligned to BLDS goals including adoption of a system of care philosophy and approach to care. 6. Supervisory Officer School visits will measure understanding of system of care values and indicators.		X	
	The modules include sessions on Human Resources, Business & Finance, Special Education, IT, etc. The focus is on developing the technical capacity of leaders as the DSB moves to a system of care.	Newly Appointed Administrators (induction):	Facilitation & Facilities for Programme (supply coverage, resources, guest instructors) = $1 500 Support resources = $1 500. Catholic Leadership Framework Principal Mentoring; Module Materials Joy of Conflict Resolution (Paperback) BIPSA Strategic Directions System of Care Handbook			X	
	Foster understanding and application of the Catholic Leadership Framework in an effort to build capacity in the development of a system of care	Administrators (Instructional Leadership & Operations)	Facilitation & Facilities for Programme (supply coverage, resources, guest instructors) = $5 000 Support Resources = $6 846 Catholic Leadership Framework SEF Instructional Rounds BIPSA Strategic Directions System of Care Handbook			X	
Reinforcement of the change (sharing of data and student and family stories about the effect of SOC)	Our school and system leaders will continually improve their ability to influence the quality of care to support students and families through the move to a system of care.	All Administrators	Our BLDS goal to support the goal to move to a system of care involves the following look fors: To this end, we will focus on building capacity among our school and system leaders to use two of the personal leadership resources identified in the Ontario Leadership Framework (OLF) and enact three of the key leadership practices from the OLF to better be able to be effective change agents. These are as follows: Personal Leadership Resources: • enhancing self-efficacy and helping staff develop self-efficacy (from the set of Psychological personal leadership resources in the OLF), as applied to leading improvement in student and family care through the	BLDS Committee			X

			implementation of a system of care philosophy and corresponding approach • Knowledge about school and classroom conditions with direct effects on student learning and well-being (from the set of Cognitive personal leadership resources in the OLF), as applied to meeting student needs (especially mental health needs). Leadership Practices: • creating high expectations (from the Setting Directions domain in the OLF) • stimulating growth in the professional capacities of staff (from the Building Relationships and Developing People domain in the OLF) • building trusting relationships with and among staff, students, and parents (from the Building Relationships and Developing People domain in the OLF) To achieve our goal, we will target our efforts towards aspiring and current school and system leaders, with additional differentiated support provided for newly appointed school leaders and their mentors. In setting this BLDS goal, we considered the results of our BLDS impact assessment and decided to focus on increasing the following impacts, most of which we gave a "0" or "1" rating: • New and experienced leaders confirm that learning, training, and development opportunities are helping them attain the goals in their Annual Growth Plan and Performance Plan, as well as the goals in their School Improvement Plans. • School and system leaders demonstrate the leadership practices and personal leadership resources described in the OLF in ways that are appropriate to their local circumstances. • Candidates who are ready to assume leadership roles demonstrate the practices and personal leadership resources set out in the OLF. • School leaders facilitate collaborative work among staff to improve the quality of instruction and care in their schools. • School leaders are knowledgeable about the quality of instruction and care in their schools and are implementing			

			strategies for instructional improvement. • Central office departments collaborate to support school improvement goals and the BIPSA. All school leaders in our district should be linking the goals in their Annual Growth Plans including system of care development with Plans and Performance Plans to their SIPSA goals. At the district level, we should use these Annual Growth Plan and Performance Plan goals to understand principals' and vice-principals' learning needs especially as these relate to leading change to a system of care and respond by organizing differentiated support and development opportunities to help them attain the goals, especially that of moving to a system of care.				

Table 5: The DSB Leadership approach to system of care development (adapted from DSB, (2016d).

Although school leaders in the DSB have made great strides in supporting improved literacy and numeracy instruction in their schools, they need to become more adept at attending to student well-being. To achieve this goal, it is critical that they feel confident about facilitating collaborative work among staff that focuses on fostering student well-being and know what to look for in students and families to determine whether the system of care is improving services and outcomes for students and families.

The DSB recognizes that school and system leaders play a critical role in achieving its School Improvement Plan for Student Achievement (SIPSA) and Board Improvement Plan for Student Achievement (BIPSA). They are also acutely aware that strengthening leadership practices and personal leadership resources will, over time, help it achieve its goals. It is affirming to note that the DSB has also selected the leadership practices and personal leadership resources to advance initiatives focusing on student well-being. Strengthening leadership practices in the coming year will be an essential starting point for the kind and nature of capacity building necessary for system leaders to advance practice to improve the well-being of students and families.

Communications Plan

Communication is a strategic activity designed to raise awareness, inform, enlighten, and guide stakeholders and key decision-makers in understanding, supporting, and sustaining a system of care. Both external and internal communication strategies are important (Pires, 2002). External communication informs the public about the system of care and generates support, while internal communication ensures an ongoing exchange of information among key stakeholders within the system of care, including staff at all schools.

The purpose of a communication plan is to provide a messaging strategy designed to change the awareness, knowledge, attitudes, and behaviours of those involved in the schools and youth mental health system in the Region. Whether client, parent, provider, referring educator, or concerned classmate, every citizen of the Region can play a role in how youth mental health care is accessed and perceived. An effective communication plan will help ensure that the awareness of and need for a system of care is persuasively presented to key stakeholders such that it actively engages them in the process and shapes the way the effort is perceived by everyone affected by the initiative.

Enacting the communication plan will be essential at the outset of the introduction to a system of care to raise awareness and obtain support. Key to this process are: developing a clear articulation of the system of care program goals; articulating a social marketing/communication plan for the long- and short-term goals of the system of care; identifying and defining key audiences, including primary and secondary audiences; developing key messages aligned to the communication needs of specific audiences; determining communication channels; testing communication strategies; and, implementing and evaluating the plan (System of Care Community Social Marketing Plan: Instructions and Template – Elements of a Strategic Communications Plan: Technical Assistance (SofC CSMP, nd).

Situational Context

The Region in which the DSB is housed is home to a traditional, fragmented, non-system of care model for children and families, including those with mental health needs. The need to achieve a sustainable and effective model for a system of care persists in Ontario, a notion reflected in Ontario Special Needs Strategy (Ontario Ministry of Children and Youth Services et

al., 2014). This has been documented as being the case across much of Canada (Shanley et. al., 2008; Bijl et. al., 2003) and in Ontario (Kutcher, 2011; Pepler et. al., 2011). Accordingly, the DSB wants to achieve a sustainable and effective model for a system of care. The social, emotional, physical, psychological, and intellectual needs of students are not being fully met due to barriers which prevent collaboration between all partners in the community in the schools (Ontario Ministry of Children and Youth Services et al., 2014). Consequently, there is interest in and political will to implement a system of care within the DSB. Strengths, weaknesses, opportunities, and threats to the implementation of a system of care have been presented earlier in this document (see SWOT Analysis, Table 2) and will need to be considered in developing and implementing the communication plan.

The communications plan will help move the DSB and the Region to become a place where children, youth, and families of any cultural or ethnic background feel comfortable asking for help and know where to access high quality mental health care without worrying about feeling judged. To bring this vision closer to reality, the communication plan must work to change the perceptions of key audiences that are involved in youth mental health care.

Program Goals

The program goals for the DSB system of care have been articulated throughout this document. The primary program goal is to develop within the DSB, and its communities, a "spectrum of effective, community-based services and supports for children and youth with/or at risk for mental health or other challenges and their families, that is organised into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and

linguistic needs to help them to function better at home, in school, in the community, and throughout life" (Stroul et.al., 2015, p.3).

Marketing Goals

It is generally accepted that the purpose of social marketing efforts is to apply and adapt commercial marketing concepts to the planning, development, implementation, and evaluation of programs that are designed to bring about behavior change to improve the welfare of individuals or their society (SofC CSMP, nd). To ensure that an awareness and need is created for implementation of a system of care in the DSB and its communities, the marketing goals must not only include awareness about the inherent inequities within the current system but create an awareness and desire to build a better future for children and families. Thus, goals for each must be articulated.

a) **Current System**

- Inadequate range of services and supports;

- Lack of individualized services;

- Fragmented system even though children and families have multi-system needs;

- Children with special needs are in many systems;

- Lack of clear values or principles for the system;

- Lack of clarity about the population of children to be served;

- Inadequate accountability; and

- Inadequate responsiveness to cultural differences. (Douglass, 2006, p.32).

b) **Desired System (System of Care)** (Stroul et. al., 2015)

- Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.

- Community based, with the locus of services, as well as system management, resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level

- Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports

- Ensure availability of and access to a broad, flexible array of effective, evidence-informed, community-based services and supports for children and their families that addresses their physical, emotional, social, and educational needs, including traditional and non-traditional services as well as informal and natural supports

- Provide individualized services in accordance with the unique potential and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family

- Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate

- Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their communities, states, territories, tribes, and nation

- Ensure cross-system collaboration, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management

- Provide care management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that children and their families can move through the system of services in accordance with their changing needs

- Provide developmentally appropriate mental health services and supports that promote optimal social and emotional outcomes for young children and their families in their homes and community settings

- Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult-service system as needed

- Incorporate or link with mental health promotion, prevention, and early identification and intervention to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents

- Incorporate continuous accountability mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level

- Protect the rights of children, youth, and families and promote effective advocacy efforts

- Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status,

geography, language, immigration status, or other characteristics; services should be sensitive and responsive to these differences.

Establishing Social Marketing Goals

The System of Care Community Social Marketing Plan (SofC CSMP, p. 4) argues that the "social marketing plan should be a 'living' document . . . one that grows within your system of care". Goals need to be set for the long- and short-term. Questions that collaboratively need to be addressed by the DSB and its partners include:

- What issue is most important to your program right now?

- Who is most affected by this issue?

- Who makes decisions about this issue?

- How do your communications goals serve your program goals?

- What is the overall communication goal you want to achieve?

- What tangible outcomes would you like to achieve through a communications effort?

- How will you know you are achieving your goals? What or who could motivate change or action (SofC, CSMP, p. 2).

Audience Identification. Defining key audiences and tailoring communications to their role and potential involvement in the development is key to the success of a communications plan. It is suggested that all stakeholders will have messages communicated to them through various means including print, electronic, and face to face messaging. Most communication will be two- way in that responses will be welcomed and in turn, responded to in a timely manner. The intent is to build the awareness and knowledge needed to propel the change to a system of care and ensure that stakeholders are informed and engaged at all stages of implementation and beyond.

Initially the communications strategy will be directed to senior management, principals, and vice principals, who would then be charged with engaging all staff. The next phase would involve expanding the communication plan into the Region by connecting with service providers and families.

Audience members would include:

- School and board staff

- Families with children and youth with mental health challenges

- Juvenile justice

- Child welfare

- Mental health and substance abuse professionals

- Primary health care

- Other community organisations

- Other community members

As such, the communications plan reaches several audiences. These include the children, youth, and families who need and/or are receiving services through the system, as well as the primary and secondary providers of services (i.e., educators, service providers, policymakers and system partners). At the outset, it is imperative that educators (principals, teachers, and support staff) receive information, as the most critical roles of this audience is to understand and work toward the development of a system of care as change agents and providers of information about a system of care to other audiences. Because educators act as communication channels to other audiences, the resulting approach is one that puts the other audiences at the core, surrounded by the educators to ensure that all stakeholders become proponents of a system of care.

Families. The families are the key players when it comes to presenting a child who needs services into the system. As a result, they must know about the system of care so they can be introduced into the system by a physician, other health care provider, or educator. It is important to make information about the system of care easily accessible and supportive in tone. The communication must highlight that the interaction within a system of care will be a positive one.

Communicating with families who speak English as a second language and/ or come from a different culture from the predominant one will be of critical importance to avoid miscommunication that can cause confusion for youth with mental health challenges and their families. Principals, teachers, and school mental health workers will play a critical role in identifying those who need access to the system of care within these populations and help ensure their understanding of what a system of care is. The school is a key entry point.

Children/youth. Children and youth with mental health challenges who need to access the system of care will most often do so via a parent or guardian. The message of what a system of care is and why we need it will reach young people through parents and secondary audiences.

Educators/Service Providers. It is equally important to communicate with educators and health care and behavioral health service providers to focus the messaging of what a system of care is and why we need it. These people can, in turn, reinforce the messages with families, youth, and children. By nature of the roles they play in the system, these audiences act as powerful word-of-mouth conduit for the messaging of the system of care. Resources spent communicating with these groups will support, bolster, and serve as the foundation of communications with the primary audiences (children, youth and families).

Policymakers, System Partners and Internal Stakeholders. The communications plan calls for communicating directly with policymakers about the impact a system of care could make on the community's and province's economy and the lives of its citizens. Educators and service providers can also help communicate with this group. The goal of these communications will be to directly affect policy discussions and cause change in policy that facilitates the adoption of a system of care. The decisions made here will directly affect all audiences, so the plan must actively promote the involvement of families, youth, educators, and service providers to ensure that policymakers hear their desire for a system of care philosophy and framework.

The internal stakeholders consist of the schools (led by principals), board administration, and service providers working to build the system of care in the Region. With this audience model in mind, the communications plan is created around tactics that are focused on initial training of the primary audiences (educators) with the intent of using them as champions through direct message interaction and through the secondary audiences including policymakers and system partners

Key Messages

The first step in implementing and defining key messages involves the development of a SWOT Analysis (i.e., developing a clear understanding of what are barriers and benefits to key audiences). Presented earlier in this document, Table 2 outlines the Strengths, Weaknesses, Opportunities, and Threats associated with a system of care. This data informs the kind and nature of communication messages that will need to be developed and to whom these messages should be directed. Spending time examining issues such as who are the key stakeholders, what are their concerns with regard to children's mental health and well-being, are there strong ethnic

and cultural communities that require more carefully tailored messages, are there potential

grassroots organisers and leaders who could be convinced to assist, should messages be tailored

to the media, and so on will be important to determining the content of messages and where and

how the targeted audiences seek and receive information. There are a plethora of ways in which

messages about systems of care can be communicated and knowing the answers to the above

questions help ensure that the messages are not only read by audience members but resonate with

and drive them to action.

It is important that the messages themselves must be closely tied to the goals of one's

initiative, deliver important information about the initiative, and compel the reader to think, feel,

or act. As such, they should:

- Show the importance, urgency, or magnitude of the issue

- Show the relevance of the issue

- Put a "face" on the issue

- Be tied to specific values, beliefs, or interests of the audience

- Reflect an understanding of what would motivate the audience to think, feel, or act

- Be culturally competent

- Be memorable (SofC CSMP, nd, p.8)

The following system of care resources will be of great assistance in constructing

messages that appeal to specific audiences.

Communication Strategies

There are a wide range of channels through which messages may be delivered to prospective audiences. Again, the System of Care Community Social Marketing Plan recommends that answers to the following questions will facilitate the identification of which strategy best fits the audience.

- Where and how does this audience group seek other sources of support and spend their time?

- What are their gender, ethnicity, and income level?

- How have they been educated?

- What are the language considerations?

- What or who are they influenced by?

- What makes new information credible for them?

- What or who could motivate change or action (SofC, CSMP, p. 10)

Answering these questions will inform the message channels that are unique to the communities served. Consideration will also need to be directed toward determining the activities, events, and/or materials that will most effectively carry messages to the intended audiences. For example, video presentations, open houses, promotional items, brochures, and family gatherings might best serve the needs of local families while policy makers might best be influenced through news releases, news conferences, letters to the editor, and opinion editorials.

Message Channels
Potential message channels that could be utilized include:

- Newswire

- Twitter
- Board Website
- Facebook
- LinkedIn
- Notes home from school
- Telephone calls
- Town hall type meetings
- Time at school assemblies
- School newsletters
- Presentations at various collaborative tables (e.g. Children's Planning Table)
- Email

The primary objective in employing a variety of channels will be to keep all stakeholders informed and seeking feedback at all stages of the change process. To reach all audiences in the most context- and channel-appropriate, cost-efficient, and effective way, the communications plan will use a variety of strategies. At its center is a page on the board user-friendly website of the DSB that will be targeted to serve all audiences. The website will serve as the content foundation and rallying point that all other communication channels reference, promote, and reinforce. In all phases of the communications plan, the user-friendly page on the Board website would be an evolving resource for all audiences. Other stakeholders would be encouraged to include links to this page on their own websites.

Phase 1. This phase will focus on ensuring principals and school staff have an excellent understanding and passion for developing a system of care. It will also focus on content and message development describing current conditions, what a system of care is, and why we need it for audiences outside the school system. It will present best practices and results from other areas which currently have a system of care. This would include stories from families who have children and/or youth with mental health challenges and educators/providers who have worked

with such children, youth, and families. Identified needs and strengths in our community will be identified which lend themselves to the successful development of a system of care. Other materials will be targeted to specific audiences, to include social media, possibly radio and television service announcements, billboards, printed materials, print advertisements, and social media. This information will be provided in a variety of languages.

Phase 2. The beginning of phase 2 will see the webpage launched and other information distributed. A news release, news conference, and stories developed by principals and other key stakeholders with press kits will be part of the launch. This will be a promotional year focused on encouraging families, educators, and service providers across the region to interact with the website page. In addition to distributing the other materials developed in Year 1, outreach strategies will include meeting with parent groups, professional associations, and attending community and political events to discuss resources available on the website. Because the website is the focal point of information for key audiences, attention will be given to modifications according to feedback. During this year paid print, TV and radio buys will begin, including in languages other than English.

Phase 3. Development will begin on the creation of short video documentaries based on the stories that have continued to be collected. Documentaries will feature children, youth, families, educators, and provider perspectives. When complete, these will be placed on the website and the board's YouTube channel and be promoted via a news conference, news releases, and promotional efforts with system partners. All other social marketing and communication efforts will continue.

During this year, follow-up focus groups and surveys will be conducted to identify understanding of intended messages to all audiences. The effectiveness of current efforts will be evaluated to determine what strategies and messages need to be freshened or changed for Year 4 and beyond.

Phase 4. The website, other materials and outreach (meetings etc.) strategies will be re-developed based on feedback from the focus groups and surveys. This will position the communications plan to continue as a constant in the hopes that system of care initiatives within the Region would expand to other provincial, national, and international sites.

Evaluation of Communications Plan.

A. Strategy for evaluation. After the stakeholders are convinced of the need for a system of care and move forward to begin development, the primary evaluation over time will be of the adherence of the system of care to established system of care values and characteristics as documented in the literature.

B. Develop outcome measures. System of care measurement tools will be used to measure success of the change to system of care process, as well as at regular intervals to measure the efficacy of the system of care once established.

C. Create a timeline and budget. The communications strategy will be ongoing and the cost will be minimal as existing DSB communication channels will be used. This will have to be re-evaluated during the community implementation stage.

D. Develop a calendar. A timeline for implementation will be developed which each school and partner in the system will be obliged to follow. Contextual differences may necessitate modification of this calendar depending on challenges encountered, which will be

different at each school. This will also have to be re-evaluated during the community development stage.

   E. Communications budget sheet. As per board processes, a full and transparent accounting of costs incurred will be documented. This will have to be re-evaluated during the community stage as the school board will not be solely responsible for implementation and monitoring.

Conclusion

   This organisational improvement plan (OIP) describes a way to develop and implement a system of care philosophy within a district school board with the intent of spreading this philosophy throughout the district, province, and country in the future. It is intended to be used as a tool to guide other district school boards interested in implementing a system of care.

   The problem of practice this OIP is intended to address is as follows: "The current model of care for JK-8 students with mental health needs must improve. The service delivery system and pathways to treatment for child and youth mental health in Canada, and in Ontario specifically, are costly, highly fragmented, and difficult to navigate for families and children (Shanley, Reid, & Evans, 2008; Pepler & Bryant, 2011). A system of care is a better way to meet the needs of children and youth with serious mental health challenges and their families as compared to the current fragmented system (Stroul, Blau & Friedman, 2010). Specifically, the OIP addresses the question "What leadership capacities are necessary to develop in principals and vice principals within an urban district school board to create a readiness for change to a system of care for child and youth mental health?"

This OIP can be generalized to suit other organisations outside education, including agencies, municipalities, and provincial and national governments. A definition of a system of care is offered along with the accompanying values and principles for system management approaches and principles for service delivery. In addition to educational services, components of a system of care include mental health services, social services, health services, vocational services, recreational services, and operational services. Development and management of a system of care in a district school board involves strengthening relationships with all services, a change in system management models, and case management and review committees agreeing to abide by the definition, values, and principles of a system of care. This is opposed to the current model which is fragmented and only abides by some of the values and principles of a system of care some of the time for some of its students. Assessment, with respect to readiness to change, equity, and adherence to system of care structures, values, and principles is offered, as well as the tools themselves which are to be used initially and at regular intervals at all stages of development and implementation. The plan is to continue to move ahead with implementation of the values and principles, as well as a common understanding of the definition of a system of care, in the district school board and progress with this work as per the model for managing change.

The works of Fullan; Cawsey, Deszca and Ingols; and, Bolman and Deal, among others, will be central in managing and making sustainable this necessary change from the current fragmented, non-system of care to a system of care as envisioned by Stroul et. al. (2015).

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Curriculum Vitae

Derek Haime

•Building our Catholic Community •Improving Student Outcomes • Inspiring Systemic Change

EXPERIENCED CATHOLIC EDUCATIONAL LEADER

...dedicated to guiding students to succeed while inspiring an insatiable passion for our faith and learning

Visionary Catholic Leader, Team Builder and Educator currently completing a Doctorate in Educational Leadership and possessing a Master's Degree in International Education (School Leadership) coupled with over 20 years' experience instructing, leading and learning with Catholic secondary and elementary students, staff and families- including the last 5 school years as superintendent of education.

SUMMARY OF QUALIFICATIONS

- An enthusiastic, creative, and passionate Catholic educator, mentor and advisor who believes that all children can learn and thrive in a learning environment that is stimulating, comforting and appropriate to their unique talents and abilities.
- Specializations include: Educational Leadership (EdD)International Education(MEd), Special Education and Religious Education
- Instructional Leadership: Demonstrated leadership at the school, board and provincial levels.
- Leverage Resources / Strategic Collaborations – Work closely with diocesan leaders, district leaders and community partners to develop close ties with our Church, effective parental involvement, accountability and strong community alliances to ensure that Catholic faith, community and culture is always the focus.
- Building relationships developing people and the organisation is my strength.
- Utilize a visionary approach with consistency to set direction for all to help students past the threshold of *not-knowing* to *knowing* and develop to their fullest extent- heart, soul, body and mind.
- Extensive experience with 21st Century learning and technology- especially assistive technology.

HIGHLIGHTED CATHOLIC EDUCATIONAL LEADERSHIP EXPERIENCE

Waterloo Catholic District School Board, Kitchener, ON.   2011/2012-Present
Superintendent of Education

Highlighted Achievements:

- OCSOA Mentor-Coach since 2012/2013
- Labour Management Team Member
- Audit Committee Team Member
- Waterloo Region Crime Prevention Council- First Nations, Metis and Inuit Representative
- Chair, Board Office Working Conditions Task Team
- Vice-Chair, Catholic Curriculum Corporation, 2013/2014 – Present
- Chair, South-East Galt Accommodation Review Committee 2011/2012-2012/2013
- Founder and lead editor for development of the board Equity and Peacemaking Resource
- Founder, Waterloo Region Restorative Justice Community Circle
- Co-Founder, Waterloo Region Aboriginal Academic Advisory Council
- Co-Developer, 2014-2015 WCDSB Faith Development Theme, "Living Our Faith" with Father Fred Scinto, and WCDSB staff.
- Facilitator and organiser, senior administration faith development series, "Fostering Faith" with Father Frank Freitas (2012/2013-2014/2015) and Christian Education Leadership Formation with Father Roger and Sister Margaret, Loyola House (2011/2012-2012/2013).
- School Superintendent having had a variety of schools and portfolios including: Faith Development, Religious Education and Family Life; Equity and Inclusion, Summer Learning Program, Safe Schools, FNMI Education, CPIC, Physical Education, Athletics and Healthy Living, BIPSA, FSL, ESL, the Arts.
- Board Representative on numerous local and provincial boards and groups including the Hamilton Diocesan Steering Committee

CATHOLIC DISTRICT SCHOOL BOARD OF EASTERN ONTARIO, Kemptville, ON.
Secondary and Elementary School Principal (4 Schools), Classroom Teacher, Special Education Teacher.
2004/2005 – 2010/2011

Highlighted Achievements
- Faith and Instructional leader, teacher and co-learner: of an alternative high school primarily of students with significant learning and behavioural challenges; of a JK-8 (Core and French Immersion) elementary school of over 300 students; of a JK-8 rural elementary school of 100 students; of a Grade 6-8 rural elementary school of 100 students featuring core, extended and French immersion.
- Led staff in using innovative methods and materials to produce effective learning experiences including cooperative learning and student led social justice initiatives, teaching learning critical pathways, student support leadership initiative, experiential learning, team teaching and differentiation.
- Contributed to a significant increase in student performances on standardized testing, especially in our focus area "Making Connections" which resulted in interest from the Fraser Institute.

- Further developed increased Adult Faith Development among staff and increased community and parish involvement in the school and involvement by the students and staff in the parish and larger community.
- Mentored and coached students and staff to help boost their confidence and competencies.
- Assisted families to genuinely express the high expectations they have for their children.
- Provincial presenter and moderator for the Leading Student Achievement Project (LSA)
- Led a change from being a JK-8 school to becoming a Grade 4-8 school due to a desire from parents for early French Immersion.
- Worked with my superintendent and the community to facilitate a school closing in a transparent and cooperative way with the entire community.

Various Schools in the CDSBEO 1992/1993- 2003/2004
Elementary School Teacher (All grades from 1-8)

Previous experience as a welder, machinist, lifeguard/swimming instructor, farmer and in various retail and commercial businesses.

COMMUNITY SERVICE

-Served 3 years on the St. John Parish Council, Perth (2002-2005)
-Member of the St. John Choir (1993-Present)
-Lector, Eucharistic Minister, Usher. (On-going at St. Jerome, St. Francis)
-Coach, manager, executive member, fundraiser in various local soccer and hockey clubs (1993-2012)
-Regular volunteer for the Perth and Lanark Civitan Service Clubs
-Foster Parent with the Children's Aid Society from 2000-2012

EDUCATION
Doctor of Education in Educational Leadership, Western University –2013-2016
Master of Education in International Educational Leadership, Charles Sturt, Australia –2011
B.A. /B.Ed., Sociology, Lakehead University, Thunder Bay, ON – 1993