

# YEAR FIVE

Discover, Design, Deliver  
2026-2027 Operational Plan

# Our Vision

A community where all children, youth and their families are provided with timely mental health care and empowered to thrive.

# Our Mission

To build resilience through holistic, evidence-informed and compassionate care, and to advocate for children, youth and families with mental illness.

# Our Values

CASA's values form the foundation of how we relate to our patients and families, to each other, to our partners, to our donors and to our funders.

## **COMMUNITY**

We believe each person's community is unique, and is needed to support the mental health and well-being of those we serve.

## **CHILD-CENTRED AND FAMILY-INCLUSIVE CARE**

As partners in care, we build services around the specific needs of each child and family.

## **COLLABORATION**

We work together to better serve children, youth and families.

## **EQUITY, DIVERSITY AND INCLUSION**

We create a culturally safe environment that acknowledges and respects the lived experience of every person and community.

## **OUTCOMES-BASED ACCOUNTABILITY**

We commit to and deliver effective outcomes as both a care provider and employer.

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# Discover, Design, Deliver: Introduction from the CEO

The theme for our 2026-27 operating plan is discover, design, deliver. This marks the final year of our five-year strategic roadmap. For the past four years, we have realigned our programs, built new relationships, solidified our legacy programs, grown new programming and expanded across Alberta. We are now in a year of reflection and discovery as we design our next five-year roadmap. This is a year where CASA Mental Health will continue to gradually grow, build two new facilities and continue to deliver much-needed mental health services across Alberta.

**Over the past year, CASA has accomplished much to be proud of:**

- **Our teams completed approximately 80 per cent of our 2025-26 operational plan deliverables.**
- **We improved family-inclusive care, increased staff and patient safety through trauma-informed training, improved medication management and opened our Trauma program in Calgary. In addition, we implemented our VPN and established an effective new help desk ticketing system.**
- **We celebrated successes, surpassing our goal to serve 11,500 children, youth and family members this past year,** opening 10 more CASA Classrooms in eight new communities (for a total of 28 classrooms serving 21 communities) and expanding our donor base, securing more than 850 new donors, exceeding our fundraising goal and securing a \$5.5M donation from Suncor – our largest one-time donation to date.
- Two areas that we are still working on and will finish in 2026-27 are the manager guide and leadership framework, and enhancing Indigenous services through improved coordination of care and access to psychiatry.
- **We hired 159 new employees, bringing us to a team of 506.** And we also learned that we need to continue to focus on process, quality, role clarity and improved interdependencies between teams and departments.
- **Through enhanced demographic data collection, we continued to learn more about the people we serve so we can serve them better.** Six per cent of our patients and families identify as black, South Asian or Latin American while 19 per cent (up from eight per cent the year before) identify as First Nations, Métis or Inuit. Fifty per cent of our patients' families have household incomes of less than \$100,000 while 58 per cent have post-secondary or post-graduate degrees. Seventy-eight per cent of our patients live in a two-parent family home, while 22 per cent live with one parent.
- **We received valuable feedback from the patients and families we serve.** Overall, 81 per cent of families who completed satisfaction surveys indicated they were satisfied with the services their child received. In our CASA Classrooms program, 90 per cent of the kids served said their mental health improved, and 100 per cent of the caregivers indicated they saw improvement in their child's mental health.

These accomplishments and learnings support our 2022-2027 roadmap and help us plan a fifth year that is focused on discovering more about our patient's journey and how we best support them, designing our new five-year roadmap and continuing to deliver high-quality, effective mental health programming across the province.

**This plan for 2026-27 includes operational deliverables focused on:**

- Developing a new roadmap and organizational structure.
- Delivering quality services while focusing on small incremental improvements to improve the patient journey.
- Continuing to expand services across Alberta, including opening seven more CASA Mental Health Classrooms and building two new CASA Houses in Fort McMurray and Calgary.

With a dedicated team, a committed board of directors and engaged supporters and partners, we are confident that we will finish the last year of our roadmap strong, ensuring more children and youth receive timely mental health care services closer to where they live, learn and play. We are also confident that we will continue to achieve the roadmap goals as we continue to envision a community where all children, youth and their families are provided with timely mental health care and empowered to thrive.

# Serving the Missing Middle

CASA Mental Health is re-envisioning the delivery of children’s mental health services in Alberta by providing culturally-safe, wrap-around mental health services to kids and youth aged three to 18 in Alberta and their families, in what we call the “missing middle.”

In the “missing middle,” CASA provides mental health treatment for diagnosed children and youth in between prevention and promotion in primary and community care, and acute treatment in hospital.

CASA operates within a standardized level of care system for children and youth developed by the American Association of Community Psychiatry and the American Academy of Child and Adolescent Psychiatry. CALOCUS (Child and Adolescent Level of Care Utilization System - see image below) is a standardized tool used to determine the intensity of services needed for children and adolescents aged six to 18.

In this system, levels 0, 1 and 2 identify services of prevention, promotion and early intervention/treatment that are best delivered by primary care networks, community organizations and other non-profits. At the other end of the model is level 6, which includes intensive, complex specialty care services that are best delivered within a hospital or secure care facility, and are provided through Recovery Alberta.

CASA serves kids, youth and their families in levels 3, 4 and 5 - the “missing middle,” as the image below shows. Our work is more critical and needed than ever. Statistics Canada data from 2022 shows that twice as many kids aged 15 and older had generalized anxiety, compared with 10 years earlier. The same study found more than one in three Canadians with a mood, anxiety or substance abuse issue either didn’t get the mental health treatment they needed, or only partly got it.

Source: [https://www.aacap.org/aacap/Member\\_Resources/Practice\\_Information/CALOCUS\\_CASII.aspx](https://www.aacap.org/aacap/Member_Resources/Practice_Information/CALOCUS_CASII.aspx)

CALOCUS-CASII: Child and Adolescent Level of Care/Service Intensity Utilization System						
Level 0	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Prevention and Health Management	Recovery Maintenance and Health Management	Low-intensity Community-based Services	High-intensity Community-based Services	Medically Monitored Community-based Services: Intensive Integrated Services Without 24-hour Psychiatric Monitoring	Medically Monitored Intensive Integrated Services: Non-secure, 24-hour Service with Psychiatric Monitoring	Medically Managed Secure, Integrated Intensive Services: Non-Secure, 24-hour Service with Psychiatric Management
Community Partners and Primary Care Networks			Recovery Alberta/Alberta Health Services			



# Our Commitment to Inclusion, Diversity, Equity and Accessibility

## Guiding Statement

### Beyond the Policies, Behind the Humans: A Courageous Approach to Inclusion, Diversity, Equity and Accessibility

CASA has identified Inclusion, Diversity, Equity and Accessibility (IDEA) as part of our foundational values moving forward. As a major community-based provider of mental health services for children, youth and their families in Alberta, we want to create a culturally safe environment that acknowledges, honours and respects the lived experience of every person and community. We believe that organizations can be powerful platforms for social change, and that we have a responsibility towards a future that is more diverse, equitable and inclusive for all.

While building on our existing work and advocacy for mental health services, we know there is so much more that can and should be done to counter marginalization. We need to critically look at our own culture and practices. We recognize that we can serve with excellence; however, without understanding our power, privilege and historical foundations of current systemic inequities, we can still cause harm. This is a journey that will require a courageous approach as we learn to listen with humility, respectfully engage in dialogue and learn together. As part of CASA's transformational journey to becoming leaders in delivering child-centred, family-inclusive mental health services, we are committed to providing our communities with the knowledges, skills and tools to create a safe, diverse and inclusive workplace; and ensuring our organization is equipped to be a provider of safe and culturally sensitive mental health services. Our commitments represent a first step as we navigate our long-term EDI journey.

## Our Commitments

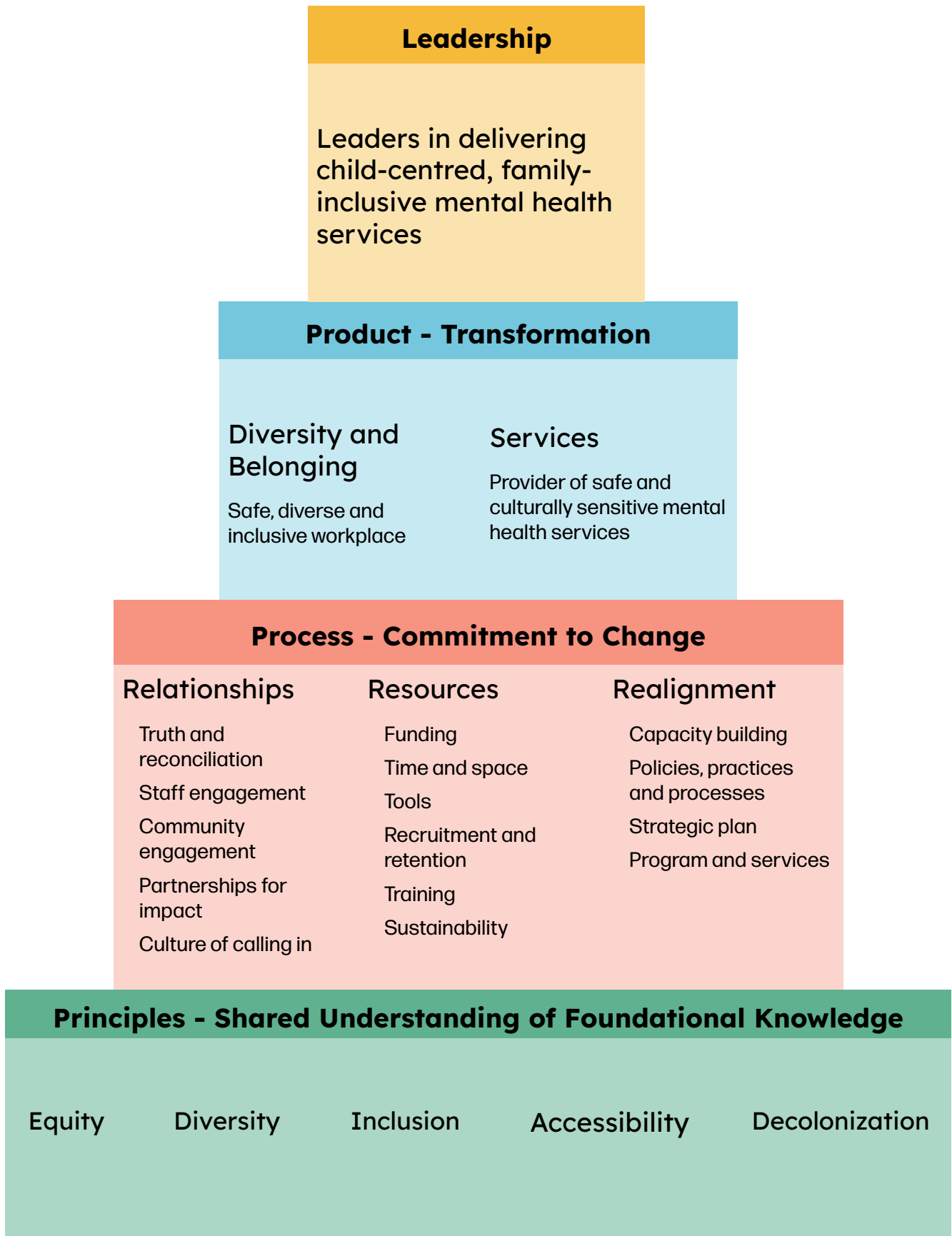
In line with embedding equity, diversity and inclusivity as building blocks of our organizational culture shift, CASA commits to:

1. Defining inclusion, diversity, equity, accessibility and decolonization as they relate to our transformation, and creating organization-wide opportunities for staff and community to meaningfully engage in building a shared understanding of this foundational knowledge.
2. Developing meaningful relationships through staff and community engagement, partnerships for impact and inclusive initiatives that will amplify truth and reconciliation dialogues, promote a culture of calling in and normalize IDEA conversations.
3. Providing resources in the form of funding, staff recruitment and retention, time, space, training and tools to ensure sustainability and continued learning and growth.
4. Ensuring organizational realignment to reflect our IDEA values through capacity building, assessment and updating of policies, practices and processes, review of programs and services, and creation of a strategic plan to guide changes and maintain accountability.

## A Lifelong Process

As we strive to create a workplace that reflects the diverse communities around us, we realize that this is a lifelong process. These commitments represent CASA's ongoing learning so changes will happen as we learn and grow in our perspectives, and as we demand better of ourselves. Creating an inclusive world involves all of us. We are building a legacy of action for a future where children and families receive equitable and culturally safe wrap-around mental health services in which they feel seen, heard and supported in a way that is uniquely meaningful to them. We aim to be a culturally safe and inclusive space where diverse staff, children, youth, families and communities can THRIVE!

# Building Blocks of CASA's Organizational Growth Towards Inclusion, Diversity, Equity and Accessibility



# Our Commitment to Mental Health Services for Indigenous Children, Youth, Families and Communities

## Ripples of Change: Honouring the Past, Acting in the Present and Re-imagining Indigenous Mental Health and Wellness for the Future

CASA is on a transformational journey inspired by our vision of a community where all children, youth and their families are provided with timely mental health care and empowered to thrive. An integral part of achieving this vision is focused on being deliberate in learning from the past, acting in the present and creating for the future when it comes to the mental health of Indigenous children, youth, families and communities. The Truth and Reconciliation Commission (TRC) issued 94 Calls to Action urging individual and collective entities across Canada to work together in a good way towards reconciliation.

### Truth First:

As an organization, we acknowledge the continuing harmful impacts of colonization on Indigenous peoples across Canada, particularly as it relates to inequities in mental health and historical trauma. We recognize that there has been an over-representation of Western values, beliefs and approaches to mental health and wellness in the lives of Indigenous peoples. This over-representation has negatively shaped our understanding of Indigenous communities and has resulted in inequitable care.

### Reconciliation in Action:

CASA's mission to build resilience through holistic, evidence-informed and compassionate care, and to advocate for children, youth and families with mental illness, must include pathways to reconciliation. The TRC called upon those with decision-making powers in health to enact relevant changes. CASA is in a unique position to support and advocate for change for First Nations, Métis and Inuit peoples on Treaty Six territory, where we are located, as well as for Indigenous children, youth, families and communities across Alberta.

In our collective journey towards reconciliation, CASA is working in collaboration with Indigenous communities on an initiative to build an **Indigenous Wellness Support Program**. The initiative aims to provide every Indigenous child and youth, and their families and communities, with mental health care that draws on Indigenous knowledges. The program will provide consultation to therapists, programs and CASA as a whole on moving towards honouring Indigenous knowledges in our work. The initiative is informed by elements of collaboration, education and consultation with Indigenous Elders, knowledge keepers, communities and co-creators of wise mental health and wellness practices that honour Indigenous knowledges.

For meaningful change to happen, we recognize the need to engage in honest dialogue, listen with humility and act with authenticity in our work with Indigenous communities. While we are learning, growing and creating, we want to start by articulating our commitments to walking together in a good way.

## Our Commitments

CASA is uniquely positioned to enact reconciliation through changes to mental health and wellness supports for Indigenous children, youth, families and communities. In response to the calls to action by the Truth and Reconciliation Commission, CASA commits to:

1. Developing meaningful relationships founded on reciprocity, respect and dialogue with Indigenous communities as co-creators of change in Indigenous mental health services.
2. Honouring Indigenous knowledges through actively learning from Indigenous approaches and perspectives of mental health, and mindfully incorporating Indigenous wise practices in our work.
3. Collaborating with Indigenous communities in identifying and building programs and services that meet their needs, and creating policies, processes and protocols to support respectful Indigenous inclusion.
4. Engaging in intentional recruitment and retention of Indigenous staff, creating safe and inclusive workspaces for them and ensuring their authentic involvement in decision-making processes.

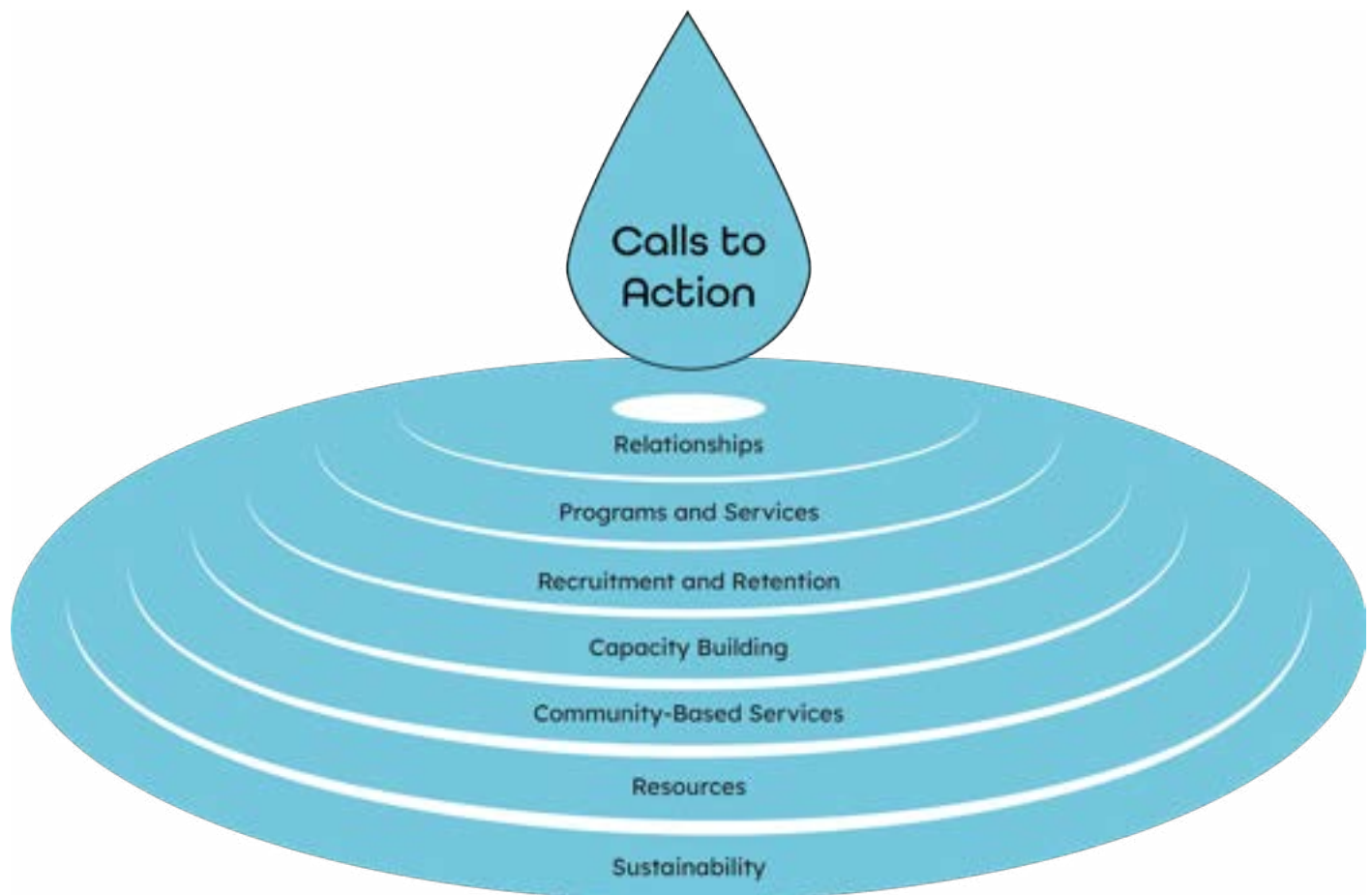
5. Developing organization-wide capacity building initiatives to equip staff for reconciliation through access to learning opportunities that promote Indigenous knowledges and prepare staff to respectfully support Indigenous health and wellness.
6. Establishing community-based services that will encourage collaborative capacity building and meaningful community involvement in developing and delivering supports.
7. Allocating resources and partnering with diverse funders to ensure adequate financing to meet the needs of the programs and services.
8. Ensuring sustainability of the programs and services through continued knowledge generation, staffing, resource allocation and ongoing relationship building that will support the evolving mental health and wellness needs of Indigenous communities.

## An Intentional Journey

*“Getting to the truth was hard, but getting to reconciliation will be harder.”  
Honourable Murray Sinclair (Chief Commissioner of the TRC)*

As we journey towards reconciliation, we recognize that these commitments represent a living process for CASA. The commitments will change and grow as we engage in ongoing dialogue and thoughtful reflections with Indigenous communities. This is inherently a process of long-term relationship building and will require patience, dedication and an intentional willingness to learn and change. Now let us journey together in a good way as we create ripples of change by honouring the past, acting in the present and re-imagining Indigenous mental health and wellness for the future.

## The Ripple Effect of the Calls to Action





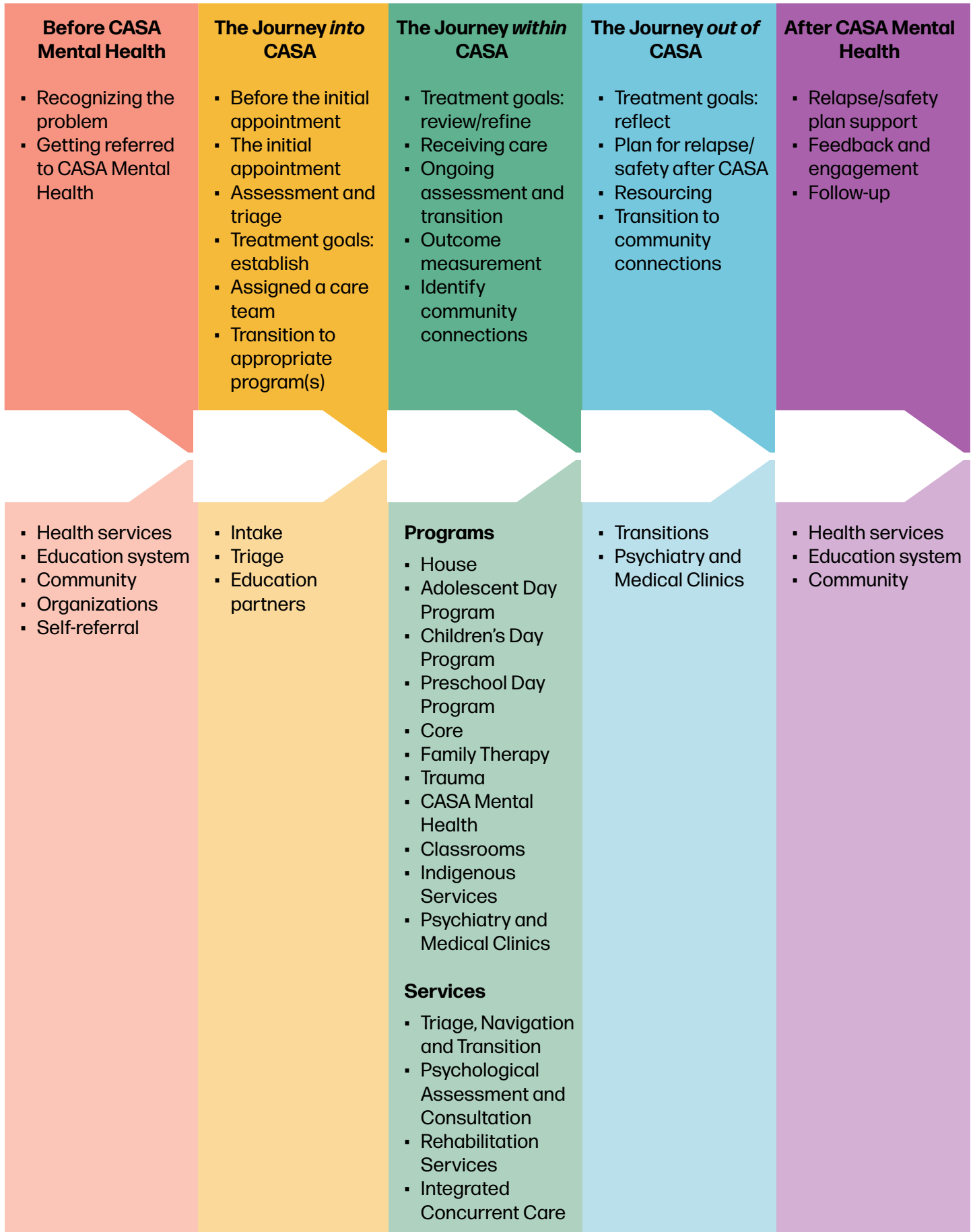
# Roadmap and Targets

# 2022-2027 Roadmap

Focus Area	Leaders in delivering child-centred, family-inclusive mental health services		Programming efficacy and relevance		Financial health	
Year Five Vision (2026-2027)	Safe, diverse and inclusive workplace.	Recognized nationally as a learning and teaching organization.	Provider of culturally safe mental health services.	Model organization in delivering trauma-informed, wrap-around mental health programming for children and their families.	Financially stable organization through diverse funding sources.	Nationally identifiable and trusted organization.
Year Five (2026-2027)	<ul style="list-style-type: none"> <li>• New organizational structure</li> <li>• New HSAA collective agreement finalized</li> </ul>	<ul style="list-style-type: none"> <li>• Indigenous learning day delivered</li> <li>• Leadership development program launched</li> <li>• Adaptive Mentalization-Based Integrative Treatment (AMBIT) practice model adopted to improve patient outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• Open one new Indigenous school-based program</li> <li>• Indigenous cultural treatment, consultation and training services integrated across programs</li> </ul>	<ul style="list-style-type: none"> <li>• New five-year roadmap for 2027-32</li> <li>• Seven more CASA Mental Health Classrooms</li> <li>• Substantial progress on CASA House builds, on budget and on time for fall 2027</li> <li>• Provincial CASA House/ADP model implemented</li> <li>• 11,750 patients and family members served</li> <li>• Map and continuously improve the patient and family journey</li> <li>• Accreditation attestation and preparation</li> </ul>	<ul style="list-style-type: none"> <li>• \$14M raised (\$3M received for annual operating + \$11M pledged for capital, with \$4.02M received)</li> <li>• Balanced 2026-27 budget with projected \$10K surplus</li> <li>• Social enterprise arm stood up and revenue initiated</li> <li>• Renewed Recovery Alberta agreement</li> </ul>	<ul style="list-style-type: none"> <li>• Grateful patient program</li> <li>• Information Technology Transformation: Year 3</li> </ul>
Year Four (2025-2026)	<ul style="list-style-type: none"> <li>• Effective medication management through a consulting pharmacist.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase staff and patient safety through trauma-informed training.</li> </ul>	<ul style="list-style-type: none"> <li>• Build capacity for enhanced trauma programming.</li> <li>• Develop service pathway to improve treatment of OCD.</li> <li>• Improve coordination of Indigenous Services care and access to psychiatry.</li> </ul>	<ul style="list-style-type: none"> <li>• Improve family-inclusive care through a family therapy clinical supervisor.</li> <li>• Promote Preschool Day Program parent confidence and competence.</li> <li>• Develop Psychiatric and Medical Clinics</li> <li>• Capital plans for four new CASA House facilities.</li> <li>• Program support specialist to improve efficiency for Family Therapy and Trauma.</li> <li>• Continue expansion of CASA Classrooms provincially.</li> <li>• Review electronic medical record.</li> <li>• Expand service to evenings and weekends.</li> <li>• Serve 11,500 patients and family members.</li> </ul>	<ul style="list-style-type: none"> <li>• Implement a purchase order system.</li> <li>• Support expansion through donor acquisition, retention and growth.</li> <li>• Explore and develop business case to diversify revenue.</li> <li>• Renew Government of Alberta Grants.</li> <li>• Achieve 2025-26 budget approval from the board of directors.</li> <li>• Raise \$4.7 million in philanthropic contributions.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop successful leaders through a manager guide, leadership development framework and HR training.</li> <li>• Assess and audit cybersecurity and infrastructure.</li> <li>• Information Technology Transformation: Year 2.</li> <li>• Implement virtual private network (VPN).</li> <li>• Implement helpdesk ticketing system.</li> </ul>

Focus Area	Leaders in delivering child-centred, family-inclusive mental health services		Programming efficacy and relevance		Financial health	
Year Three Measures (2024-25)	<ul style="list-style-type: none"> <li>65% of staff attend Diversity and Inclusivity training.</li> <li>75% of staff responding to employee survey indicate a positive rating on:               <ol style="list-style-type: none"> <li>psychological safety;</li> <li>inclusion and belonging, and</li> <li>workplace culture of managers and supervisors.</li> </ol> </li> <li>Receive Silver Level Certification as a Healthy Workplace from Excellence Canada.</li> <li>Integrated student training/placement approach established with post-secondary institutions.</li> <li>Partnership agreements with five post-secondary institutions in Alberta to support student placements and fellowships.</li> </ul>		<ul style="list-style-type: none"> <li>Increased number of patient/clients seeking our services from diverse backgrounds.</li> <li>65% of patients/families served complete a patient satisfaction/experience survey.</li> <li>85% of patients/families agree that CASA is helping to improve their child's mental health.</li> <li>Patient records are in alignment with NetCare for effective information to be shared between providers.</li> <li>At least two children's mental health programs being offered province-wide through technology-based platforms.</li> <li>Number of patients and family members served increased to 8,000 annually.</li> </ul>		<ul style="list-style-type: none"> <li>25% of revenue comes from sources other than government or Alberta Health Services.</li> <li>Three additional (and/or expanded) multi-year grants secured, through public, private or non-profit partnerships, for CASA to deliver mental health services.</li> <li>\$5M per year raised through donor relations and fundraising activities.</li> <li>CASA services will be offered in at least three physical footprints/locations occupied by a partner organization.</li> <li>100% more volunteers and 50% more volunteer opportunities.</li> <li>Increased knowledge of CASA in Alberta.</li> </ul>	
Year Two (2023-24)	<ol style="list-style-type: none"> <li>Employee well-being and resiliency strategy/program implemented.</li> <li>Integrated equity, diversity and inclusivity strategy documented.</li> <li>Electronic patient and staff safety incident tracking system implemented.</li> <li>Successfully Accredited and quality improvement plan developed.</li> </ol>	<ol style="list-style-type: none"> <li>Professional Development and Education services to external health care professionals and internal CASA Mental Health teams increased.</li> <li>Clinical therapist supervision program implemented.</li> <li>Logic models and evaluation frameworks documented for all programs and services.</li> </ol>	<ol style="list-style-type: none"> <li>Ocean software successfully launched.</li> <li>First set of patient sociodemographic and satisfaction data generated.</li> <li>School-based services delivered at Kipohatakaw Education Centre (KEC)</li> <li>Clinical pathways for the greater Edmonton area documented.</li> </ol>	<ol style="list-style-type: none"> <li>Clear organizational admission, transition and discharge pathways documented with appropriate triage and transition teams in place.</li> <li>Core program capacity increased to improve waitlist management.</li> <li>Eleven new CASA Classrooms launched.</li> <li>5,500 children, youth and families served.</li> </ol>	<ol style="list-style-type: none"> <li>Human resource information and payroll system implemented and staff trained.</li> <li>Cost recovery psychological assessment consultation (PAC) services trial complete.</li> </ol>	<ol style="list-style-type: none"> <li>100% of all archived records are cleaned up in accordance with records retention policy.</li> <li>\$3.3M net raised through donor relations and fundraising activities.</li> <li>Information technology infrastructure and expansion reviewed with recommendations for provincial footprint.</li> <li>Technology sustainability plan approved.</li> </ol>
Year One (2022-23)	<ol style="list-style-type: none"> <li>Process created and tools (eg: Ocean) adopted to collect demographic staff and patient data.</li> <li>Integrated multi-year diversity and inclusivity strategy complete with staff and physician training begun.</li> <li>Well-being and resiliency framework completed and being utilized for program planning.</li> </ol>	<ol style="list-style-type: none"> <li>Staff and physician onboarding package and process designed and being utilized at point of hire.</li> <li>Mentorship program designed and all new staff assigned a mentor upon hire.</li> <li>Physician resource plan complete and approved by Senior Leadership Team.</li> </ol>	<ol style="list-style-type: none"> <li>Patient satisfaction/ experience surveys redesigned and first set of data generated.</li> <li>All policies and practices reviewed through an equity, diversity and inclusivity lens and reframed as required.</li> <li>Patient stories/ voice integrated into board and senior leadership meetings.</li> </ol>	<ol style="list-style-type: none"> <li>Number and type of CASA programs defined and streamlined.</li> <li>Clinical framework(s) informing practice and incorporating therapeutic modalities designed and being utilized for program planning and evaluation.</li> <li>Virtual Child and Adolescent Mental Health Program Evaluation and Research Hub in place.</li> <li>Successful accreditation through Accreditation Canada.</li> </ol>	<ol style="list-style-type: none"> <li>Business intelligence and evaluation capacity in place.</li> <li>Increase number of grants pursued by 25%.</li> <li>Options paper, with recommendations, regarding creation of a profit arm for CASA complete.</li> </ol>	<ol style="list-style-type: none"> <li>New website designed and active.</li> <li>Rebranding and social media strategy completed.</li> <li>Web-based capability in place for effective donor management.</li> </ol>

# The Patient Journey



# Services Across Alberta



## CASA House

- Four locations: Calgary and Fort McMurray (2027), Medicine Hat and Edmonton relocation and enhancements (2029).
- Targeted capital fundraising goal of \$18.75 million for each CASA House location.



## Trauma Program

- Edmonton
- Calgary



## Core

- Edmonton



## CASA Classrooms

- Operational around the province. Current locations include:
  - Coaldale
  - Cold Lake
  - Calgary
  - Daysland
  - Edmonton
  - Fort McMurray
  - Fort Saskatchewan
  - Grande Prairie
  - High Level
  - Lacombe
  - Medicine Hat
  - Redcliff
  - Red Deer
  - Rocky Mountain House
  - Sherwood Park
  - Slave Lake
  - Stony Plain
  - Strathmore
  - Sturgeon County
  - Taber
  - Wetaskiwin



## Indigenous Services

- Alexander First Nation
- Alexis Nakota Sioux Nation
- Enoch Cree Nation
- Paul First Nation



## All Other Day and Specialized Programs



## Toys aren't trained for this. **CASA Mental Health can help.**

Most of us had one - the teddy bear, the sock monkey, the favourite toy that gave us comfort. For kids with mental health issues, these toys are even more important. They offer a safe space for children and youth to express themselves, a listening ear to talk to and sometimes just plain comfort during scary times and feelings. Our team members even use toys in many of their therapies.

But those toys can only do so much. Mental illness requires treatment. The teams of experts at CASA Mental Health are trained to provide medical and therapeutic care for Families. That means care and oversight from a psychiatrist, blended with the right mix of group and individual therapy, day programs and classroom or live-in care provided by a team of other mental health professionals.

**Get help or give help today: [casamentalhealth.org/toys](https://casamentalhealth.org/toys)**



# Case for Support

## The opportunity

The Government of Alberta has committed an exceptional \$75 million to fund the “bricks and mortar” for CASA’s expansion to four locations across the province. They have also made an unprecedented commitment to provide operating funding for CASA Houses once built. CASA has been asked to match the capital funding, and support expansion of programs in those areas where services are expanding.

**We know we can do it with supporters like you who care about our kids and the future of our province.**

### Together, we can:

- Extend wrap-around services across the province, including families within rural communities, to ensure both the child and their family are fully supported.
- Build integrated CASA House and day program facilities in Fort McMurray, Edmonton, Calgary and Medicine Hat over the next four years, offering both live-in and day treatment programs in the communities where teens need help.

CASA has more than doubled the number of kids, youth and families served from 4,000 to over 11,000 in just the past three years. As we learn and understand more about the importance of mental health as a key factor in a person’s life journey, more families are reaching out to CASA for our life-changing services.

**Your support helps ensure that CASA services can be available to more kids and families, and in more communities across Alberta than ever before.**



**With your support, CASA Mental Health will raise \$90 million between 2025 and 2029.** Your generosity will ensure CASA Mental Health is there for kids and families that need us. You can help our multidisciplinary teams reach over 11,000 kids under age 18, and their family members, across Alberta **at no cost to them** each year.

## Provincial Campaign Priorities

### CASA Houses: \$75 Million

Your support helps more youth who need intensive mental health treatment by bringing CASA Houses into Fort McMurray, Calgary and Medicine Hat and relocating an enhanced Edmonton CASA House. You can help us serve a total of up to 324 more youth each year who won’t have to travel so far from home to get the timely mental health care they need.

### CASA Community Programs: \$15 Million

Your donation will provide CASA programming for families who are helping their child manage their mental health. Family support is crucial for a child’s mental health as it provides emotional security, builds resilience and helps children develop coping skills, while fostering a sense of trust and belonging.



# Risk Universe

## CASA's 2026-27 Risk Universe

CASA acknowledges that risk is inherent to our operations, the nature of health-care services and the pursuit of our goal to expand services. To ensure sustainable success, CASA consciously accepts risks and explores opportunities to grow the organization and serve more patients and families. The key risk factors considered material to our business and operations are outlined below. These risks are integrated into our wider risk management processes, escalation and mitigation as required.

During 2026-27, CASA will assess and enhance its risk management program. The following risk factors reflect our mission, vision, values and priorities established through CASA's five-year roadmap and operational plan.

Each risk is reviewed regularly and given an alphanumeric rating that reflects severity and likelihood/probability, as well as a mitigation status of: on track; at risk; off track/delayed; and a discussion of what's been achieved, what's next and if mitigation is working.

### Key Risks

**Recruitment, retention and salary pressures related to essential clinical and operational roles may affect business continuity, operational capacity and timely expansion of programs and opening facilities. These challenges could impact access to care, waitlist management and CASA's reputation.**

As CASA expands its program and services, sourcing qualified and experienced professionals to meet our standards of clinical service delivery remains increasingly difficult. The market for key personnel (in our industry) is highly competitive and not concentrated in key areas in Alberta, creating challenges in recruiting the required staffing ratios for additional live-in programs.

**Organizational growth exceeds sustainable capacity, resulting in an accelerated pace of expansion that may outstrip resources, systems and oversight. This could compromise quality, consistency and effectiveness of both new and existing programming.**

Maintaining quality is core to CASA's services delivery. This requires a delicate balance between delivery of existing services and resources dedicated to expansion. While existing delivery care methods may be effective within their current scope, they must be evaluated for provincial scalability and feasibility.

**A material disruption or security breach involving CASA's information technology systems, and inability to optimize operating systems could impair clinical workflows, hybrid care delivery and operational scalability.**

CASA relies on critical technological infrastructure and robust cybersecurity practices to safeguard patient data and ensure consistent service delivery across the province. Redundancy systems and cybersecurity mitigation strategies are employed whenever feasible, with ongoing upgrades planned in this fiscal year. Increased reliance on cloud-based providers and third party applications heightens exposure to risks related to provider instability, business model changes, reduced functionality, cyber attacks or system outages.

**Funding uncertainty, increases in capital and operating costs, dependence on external funding agreements and donor fatigue may limit the organization's ability to secure sufficient resources to develop and sustain planned facilities and services.**

CASA's ability to provide services free of charge to children and families depends on the availability of funding, including government grants and funding agreements, philanthropic donations and other funding sources. Health system restructuring, current political climate and government funding agreement negotiations introduce risks associated with ongoing financial stability. Recent tax benefit changes, donor fatigue and the increased competition among organizations reliant on philanthropic support further heighten funding related risks. These factors may impact programs not fully funded through government agreements, CASA's capital expansion campaign and services partially supported by other funding.

# Assessment of CASA's Strengths, Weaknesses, Opportunities and Threats (SWOT)

	STRENGTHS	WEAKNESSES
<b>Internal</b>	<ol style="list-style-type: none"> <li><b>1. Values-driven, mission-aligned culture</b> <ul style="list-style-type: none"> <li>▪ Strong organizational identity (“missing middle”), clear mission and deeply embedded core values, including integrity, family-centred care and compassion.</li> <li>▪ Consistent commitment to inclusivity, diversity, equity and accessibility (IDEA), Indigenous-led approaches, and honouring Truth and Reconciliation principles.</li> </ul> </li> <li><b>2. Agility, innovation and nimbleness</b> <ul style="list-style-type: none"> <li>▪ Ability to pivot quickly, pilot new ideas, try emerging technologies and integrate new approaches.</li> <li>▪ Reputation for being flexible, creative and adaptive, allowing rapid development of new programming.</li> </ul> </li> <li><b>3. Strong clinical programming and integrated models of care</b> <ul style="list-style-type: none"> <li>▪ CASA Classrooms, trauma programming, psychiatry access, interdisciplinary care teams and wrap-around models unique in Canada.</li> <li>▪ Use of qualitative and quantitative data to understand patient journeys and outcomes.</li> </ul> </li> <li><b>4. Organizational relationships and collaboration</b> <ul style="list-style-type: none"> <li>▪ Strong, open collaboration between clinical and business operations.</li> <li>▪ Active and present CEO, engaged YFAC, strong volunteer base, supportive funders, expanding community partnerships.</li> </ul> </li> <li><b>5. Commitment to staff growth and learning</b> <ul style="list-style-type: none"> <li>▪ Robust internal training, professional development, mentorship and openness to new therapeutic interventions.</li> <li>▪ Staff are highly skilled, compassionate and committed.</li> </ul> </li> <li><b>6. Accessibility and removal of barriers for families</b> <ul style="list-style-type: none"> <li>▪ Zero-cost services, flexible appointment options (evenings/weekends/virtual) and efforts to reduce access barriers.</li> </ul> </li> <li><b>7. Growing reputation and trust</b> <ul style="list-style-type: none"> <li>▪ Longstanding presence in the community, seen as a trusted, safe organization with strong family and funder confidence. Competitive advantages as an expanding yet nimble organization.</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li><b>1. Rapid growth outpacing structures and processes</b> <ul style="list-style-type: none"> <li>▪ Policies, procedures, documentation and standards have not kept pace with expansion.</li> <li>▪ Operational inconsistencies across sites, programs, regions and departments.</li> </ul> </li> <li><b>2. Capacity, workload and burnout</b> <ul style="list-style-type: none"> <li>▪ Staff and leaders facing urgency culture, workload strain, burnout risk and change fatigue.</li> <li>▪ Leadership capacity and skill gaps noted across management levels.</li> </ul> </li> <li><b>3. Inconsistent communication and change management</b> <ul style="list-style-type: none"> <li>▪ Lack of clear communication pathways, uneven rollout of changes, inconsistent messaging and limited consultation before major decisions.</li> </ul> </li> <li><b>4. Role clarity and organizational structure challenges</b> <ul style="list-style-type: none"> <li>▪ Unclear delineation of roles/responsibilities across disciplines and programs.</li> <li>▪ Provincial model and reporting structures not well defined.</li> </ul> </li> <li><b>5. Infrastructure, technology and tools</b> <ul style="list-style-type: none"> <li>▪ Aging infrastructure, space constraints, EMR challenges (especially inpatient) and limited Dayforce integration.</li> <li>▪ Need for standardized business and clinical processes.</li> </ul> </li> <li><b>6. Recruitment, retention and compensation</b> <ul style="list-style-type: none"> <li>▪ Compensation not competitive with health systems, pension limitations.</li> <li>▪ Turnover in key business areas creates inconsistency in processes and documentation.</li> </ul> </li> <li><b>7. Geographic expansion challenges</b> <ul style="list-style-type: none"> <li>▪ Inconsistent awareness of CASA outside Edmonton.</li> <li>▪ Lack of understanding of new communities, remote recruitment challenges and limited director accessibility as span increases.</li> </ul> </li> </ol>

	OPPORTUNITIES	THREATS
External	<ol style="list-style-type: none"> <li><b>1. Provincial expansion and increasing visibility</b> <ul style="list-style-type: none"> <li>▪ Growing presence in new communities increases collaboration opportunities and broadens CASA's identity at a provincial and national level.</li> </ul> </li> <li><b>2. Strengthening partnerships and funding diversification</b> <ul style="list-style-type: none"> <li>▪ New philanthropic, corporate, federal and community partnerships.</li> <li>▪ Capital expansion aligns with donor and government priorities.</li> </ul> </li> <li><b>3. Leadership in children's mental health</b> <ul style="list-style-type: none"> <li>▪ System changes (i.e. restructuring of Alberta Health Services and Recovery Alberta) create openings for CASA to lead programmatically and clinically.</li> <li>▪ Opportunity to define provincial standards, licensing and proprietary frameworks.</li> </ul> </li> <li><b>4. Recruitment advantages</b> <ul style="list-style-type: none"> <li>▪ Restructuring in competitor organizations makes CASA an employer of choice.</li> <li>▪ Strong mission and culture attract talent.</li> </ul> </li> <li><b>5. Expanded programming and service innovations</b> <ul style="list-style-type: none"> <li>▪ Growth in specialized programming (Trauma, day treatment, live-in services, medical clinics).</li> <li>▪ Leveraging integrated data and improved clinical frameworks.</li> </ul> </li> <li><b>6. Storytelling and community awareness</b> <ul style="list-style-type: none"> <li>▪ Growing public awareness of mental health increases support, funding opportunities and engagement.</li> <li>▪ IDEA and Indigenous services work positions CASA as a sector leader.</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li><b>1. Workforce competition and talent shortages</b> <ul style="list-style-type: none"> <li>▪ Recruitment and retention challenges across disciplines.</li> <li>▪ Limited skilled workforce, especially in rural and remote regions.</li> <li>▪ Competition with AHS, Recovery Alberta and private sector.</li> </ul> </li> <li><b>2. Funding instability and political climate</b> <ul style="list-style-type: none"> <li>▪ Shifts in government policy, economic instability, donor fatigue and dependence on partnerships (e.g. school divisions).</li> <li>▪ Risk of funding loss due to broader provincial and federal changes.</li> </ul> </li> <li><b>3. System restructuring impacts</b> <ul style="list-style-type: none"> <li>▪ Ongoing Alberta Health Services and Recovery Alberta changes affecting lane definitions, partnerships, program stability and recruitment pipelines.</li> </ul> </li> <li><b>4. Demand exceeding capacity</b> <ul style="list-style-type: none"> <li>▪ Rising patient volumes, growing waitlists and expansion increasing service pressures.</li> </ul> </li> <li><b>5. Reputational risks</b> <ul style="list-style-type: none"> <li>▪ Public criticism by former staff or patients, overselling by partners and lack of consistent messaging in new communities.</li> </ul> </li> <li><b>6. Operational and infrastructure risks.</b> <ul style="list-style-type: none"> <li>▪ IT security vulnerabilities, rising material and facility costs and space limitations.</li> </ul> </li> </ol>



# Programs and Services

# CASA Definitions - Programs and Services

## Program

A program is a discrete, organized set of actions that use resources across the organization, to produce a desired outcome for CASA's patients. Programs differ from services in that there is intentionality around change, with goals, objectives and indicators to measure progress toward desired outcomes.

Programs at CASA are further defined as having responsibility for the patient and the patient record, as well as having a definitive start and stop date for CASA patients.

For funding: Programs stand alone and have their own product sheets.

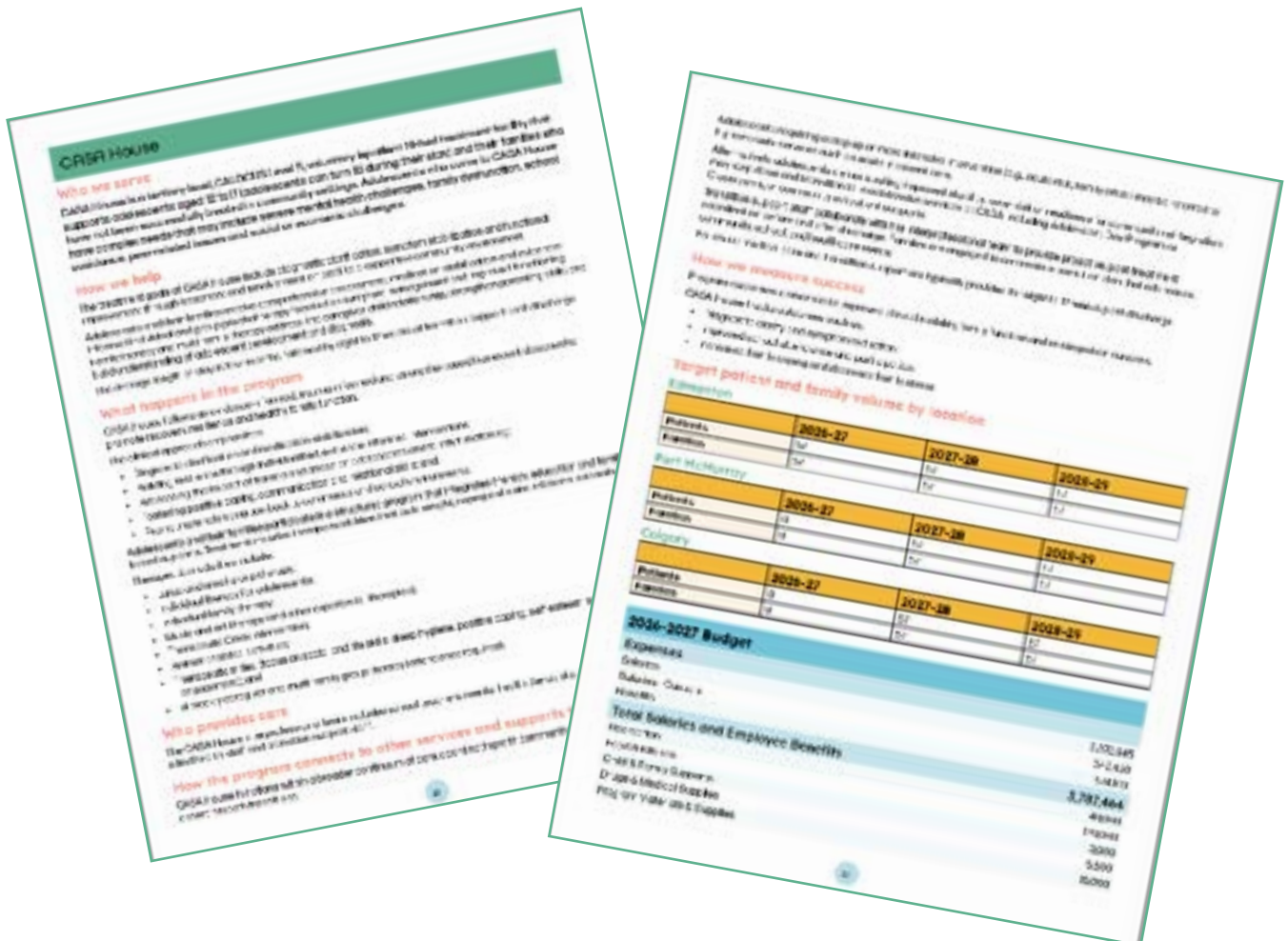
## Service

A service is an activity of providing help or support to those who provide assistance to CASA patients. Services are activities that support others in fulfilling the purpose or mission of the program or organization.

Services at CASA are further defined as those supports that do not stand alone and that provide assistance to others in producing desired outcomes for CASA patients.

For funding: Service costs are incorporated into program product sheets to ensure appropriate capture of all expenses related to each program. Services also have a separate service product sheet to capture specific service costs reportable to funders.

**For each program and service in this operational plan, you will find a product sheet, departmental budget and position allocation.**





# Clinical Departments

# Adolescent Day Program

## Who we serve

CASA Mental Health's Adolescent Day Program (ADP) serves adolescents in grades 8 to 12 requiring tertiary-level care due to ongoing emotional, psychological or behavioural challenges in attending a community school. The program provides assessment, diagnosis, therapy and medication review to adolescents at a CALOCUS level four.

## How we help

The goal of ADP is to help the adolescent and their family develop skills to enable them to experience increased success in school, peer relationships and within the family. Patients attend every school day for an average of one semester (4.5 months), which allows for two intake periods per year in September and February.

Adolescents and families receive comprehensive assessment, medication stabilization and evidence-informed individual and group psychotherapy focused on improved functioning. Family therapy and a parent/caregiver group therapy address the caregiver-child relationship, strengthen parenting skills and build understanding of adolescent development and diagnoses.

A successful return to a community school is a priority; this is achieved by planning for a successful transition together with the family and community school from the beginning of the program, as well as strengthening existing abilities and developing new skills to ensure success.

## What happens in the program

The Adolescent Day Program follows an evidence-informed and strength-based framework designed to promote recovery, resilience and healthy family function. The clinical approach emphasizes:

- Application of current brain science and neurodevelopment towards a strengths-based, resiliency approach;
- Reducing toxic stress for the adolescent through building upon strengths individually, within the family setting, and in the classroom and larger community;
- Effective learning strategies to build success across home, school and community;
- Trauma-informed interventions for the adolescent, families and staff within the program; and
- Evidence-based programming to serve individual needs (dialectical behaviour and cognitive behavioural therapy, psychodynamic processing, motivational interviewing), including risk assessment and safety planning as necessary.

Following comprehensive assessments and the co-creation of care plans, adolescents and families participate in a structured program that integrates therapy, education and family-based supports. Therapeutic modalities include:

- Group therapy (psychodynamic processing and dialectical behaviour therapy)
- Individual therapy
- Family therapy\*
- Bi-weekly parent group\*
- Art therapy
- Therapeutic milieu
- Therapeutic Crisis Intervention
- Animal-assisted activities

*\* Attending caregiver group and family therapy is a mandatory requirement of ADP*

## Who provides care

The ADP team includes teachers, mental health therapists, psychiatrists, nurses, therapy support assistants, addictions counsellors, assessment psychologists, occupational and speech therapy, and therapy support navigators. The interprofessional team meets weekly to discuss patients' assessments, goals and progress in treatment.

## How the program connects to other services and supports transitions

The Adolescent Day Program functions within a broader continuum of care, coordinating with community-based services to ensure smooth transitions. During a patient's treatment in the program, the interprofessional team may determine, in conjunction with the family, that a different level of service is required.

A step-up in service may be recommended if there are significant family dynamics that interfere in therapy progress, where space may afford the family an opportunity to gain individual skills before re-integrating and/or if a patient presents with increasing acuity in suicidal ideation or self-harm during treatment.

ADP may also be a step-down in service from higher acuity programming, as a halfway point from intensive inpatient care before transition to the community school.

These flexible transitions ensure continuity of care and alignment with each adolescent's evolving needs.

Transition support staff collaborate with the team to provide proactive, post-treatment coordination before and after discharge. Families are engaged to co-create a transition plan that addresses community, school, and health-care needs. Non-urgent, follow-up transition support is provided for a defined period after discharge, typically for another full semester.

## How we measure success

Program outcomes are demonstrated by improved clinical stability, overall family functioning and successful transitions back to school and community.

### The Adolescent Day Program tracks outcomes such as:

- Diagnostic clarity and symptom reduction
- School attendance, participation, and performance
- Emotional regulation and distress tolerance skills
- Social and interpersonal effectiveness skills
- Family functioning, parental responses and family relationship quality
- Warm hand-offs to community-based service providers

## Target patient and family volume by location

### Edmonton

	2026-27	2027-28	2028-29
<b>Patients</b>	24	24	24
<b>Families</b>	24	24	24

### Fort McMurray

	2026-27	2027-28*	2028-29
<b>Patients</b>	0	24	24
<b>Families</b>	0	24	24

### Calgary

	2026-27	2027-28*	2028-29
<b>Patients</b>	0	24	24
<b>Families</b>	0	24	24

*\*Pending capital expansion timeline adjustments and staggered opening plan*

## 2026-2027 Budget

### Expenses

Salaries	679,520
Benefits	135,904
<b>Total Salaries and Employee Benefits</b>	<b>815,424</b>
Recreation	1,700
Child & Family Supports	1,500
Program Materials & Supplies	12,000
Education, Conferences & Workshops	13,590
Team Building	805
Travel & Subsistence	2,000
Clinical Travel	2,000
Clinical Consultation	17,280
Clinical Contracts / Services	8,960
Office Materials & Supplies	2,000
Professional Consulting / Services	15,000
<b>Total Program Expenses</b>	<b>76,835</b>
<b>Total Expenses</b>	<b>892,259</b>

### Position Name

	<b>FTE</b>
Concurrent Counsellor	0.20
Mental Health Nurse	1.00
Mental Health Therapist	2.00
Occupational Therapist	0.10
Program Manager, Day Programs	0.33
Speech Language Pathologist	0.10
Therapy Support Assistant	3.00
Therapy Support Navigator	0.66
Program Supervisor	0.66
<b>Grand Total</b>	<b>8.05</b>

# CASA House

## Who we serve

CASA House is a tertiary-level, CALOCUS Level 5, voluntary inpatient 19-bed treatment facility that supports adolescents aged 12 to 17 (adolescents can turn 18 during their stay) and their families who have not been successfully treated in community settings. Adolescents who come to CASA House have complex needs that may include severe mental health challenges, family dysfunction, school avoidance, peer-related issues and social or economic challenges.

## How we help

The treatment goals of CASA House include diagnostic clarification, symptom stabilization and functional improvement through treatment and timely transition back to a supportive community environment.

Adolescents and their families receive comprehensive assessment, medication stabilization and evidence-informed individual and group psychotherapy focused on symptom management and improved functioning. Family therapy and multi-family therapy address the caregiver-child relationship, strengthen parenting skills and build understanding of adolescent development and diagnosis.

The average length of stay is four months, followed by eight to 12 weeks of transition support post-discharge.

## What happens in the program

CASA House follows an evidence-informed, trauma-informed and strengths-based framework designed to promote recovery, resilience and healthy family function.

The clinical approach emphasizes:

- Diagnostic clarification and medication stabilization;
- Building resilience through individualized, evidence-informed interventions;
- Addressing the impact of trauma and stress on adolescents and family functioning;
- Fostering positive coping, communication and relational skills; and
- Promoting timely transition back to community and school environments.

Adolescents and their families participate in a structured program that integrates therapy, education and family-based supports. Treatment includes therapy modalities that build insight, coping skills and relational capacity.

Therapeutic modalities include:

- Large and small group therapy;
- Individual therapy for adolescents;
- Individual family therapy;
- Music and art therapy (and other experiential therapies);
- Therapeutic Crisis Intervention;
- Animal-assisted activities;
- Therapeutic milieu (focus on social and life skills, sleep hygiene, positive coping, self-esteem, school engagement); and
- Weekly caregiver and multi-family group therapy (attendance required).

## Who provides care

The CASA House interprofessional team includes school teachers, mental health therapists, psychiatrists, nurses, allied health staff and transition support staff.

## How the program connects to other services and supports transitions

CASA House functions within a broader continuum of care, coordinating with community and acute services to ensure smooth transitions.

Adolescents requiring a step up or more intensive intervention (e.g., acute risk, family crisis) may be referred to higher-acuity services such as acute inpatient care.

Alternatively, adolescents demonstrating improved stability, lower risk or readiness for community reintegration may step down and transition to less intensive services at CASA, including Adolescent Day Program or Classrooms, or community outpatient supports.

Transition support staff collaborate with the interprofessional team to provide proactive, post-treatment coordination before and after discharge. Families are engaged to co-create a transition plan that addresses community, school and healthcare needs.

Follow-up medical care and transition support are typically provided for eight to 12 weeks post-discharge.

## How we measure success

Program outcomes demonstrate improved clinical stability, family function and reintegration success.

CASA House tracks outcomes such as:

- Diagnostic clarity and symptom reduction
- Improved school attendance and participation
- Increased family coping and decrease family stress

## Target patient and family volume by location

### Edmonton

	2026-27	2027-28	2028-29
<b>Patients</b>	57	57	57
<b>Families</b>	57	57	57

### Fort McMurray

	2026-27	2027-28	2028-29
<b>Patients</b>	0	57	57
<b>Families</b>	0	57	57

### Calgary

	2026-27	2027-28	2028-29
<b>Patients</b>	0	57	57
<b>Families</b>	0	57	57

## 2026-2027 Budget

### Expenses

Salaries	2,870,845
Salaries - Casuals	342,450
Benefits	574,169
<b>Total Salaries and Employee Benefits</b>	<b>3,787,464</b>
Recreation	40,000
Food & Kitchen	120,000
Child & Family Supports	3,000
Drugs & Medical Supplies	5,500
Program Materials & Supplies	15,000

Education, Conferences & Workshops	64,266
Team Building	7,400
Travel & Subsistence	2,000
Clinical Travel	5,000
Clinical Consultation	24,000
Clinical Contracts / Services	75,000
Office Materials & Supplies	5,000
Software & Subscription	3,500
<b>Total Program Expenses</b>	<b>369,666</b>
<b>Total Expenses</b>	<b>4,157,130</b>

<b>Position Name</b>	<b>FTE</b>
Behavioural Specialist	1.00
Child Care Counsellor	8.28
Concurrent Counsellor	0.80
Cook II	1.80
Licensed Practical Nurse	9.61
Mental Health Therapist	3.00
Occupational Therapist	1.00
Program Manager, CASA House	1.00
Recreation Coordinator	1.00
Therapy Support Navigator	1.80
Program Supervisor	3.00
Mental Health Nurse	1.59
<b>Grand Total</b>	<b>33.88</b>



# CASA Mental Health Classrooms

## Who we serve

CASA Mental Health Classrooms is a community-based, medically integrated, intensive school-based treatment program, focusing on CALOCUS Level 3 and 4, that supports children and adolescents aged eight to 17 who have not responded to other mental health interventions, and their families. Patients who attend CASA Mental Health Classrooms have experienced mental health concerns that interfere with emotional regulation, academic success, family functioning, school attendance and/or peer-related issues. These are patients and families who require extended and intensive clinical intervention due to functional impairments that impact schooling and home, but do not need or would not benefit from an acute inpatient admission.

## How We Help

Children and adolescents who access CASA Mental Health Classrooms are provided with more support than a community child and youth mental health service clinic or school-based counselling, with therapy-based interventions (individual and group) supported by a mental health team in the classroom, physician, other interprofessional support and ongoing transition services supporting the patients' progress towards recovery.

The treatment goals of CASA Mental Health Classrooms include diagnostic clarification, medication management, symptom stabilization and functional improvement through mental health treatment, targeted academic support and intentional transition back to their home school and community environments. Patients receive a comprehensive assessment, medication stabilization and evidence-informed individual and group psychotherapy focused on diagnostic clarity, symptom management and improved mental health and academic functioning. All treatment outcomes provided in the classrooms are shared with family, medical providers, community providers and school supports to ensure good understanding of the patient's needs, diagnostic outcomes and ongoing supports or resources.

Keeping the CASA Mental Health Classroom integrated into the school provides the opportunity to 'practice' classroom engagement in a smaller, safe, lower-pressure environment and is recognized as a positive component of the model. Patients' families are also supported throughout the program. This is done through our navigator and nurse positions who work to provide those wrap-around supports in the community.

The CASA Mental Health Classrooms Parent Program supports families to improve parent-child relationships and enhance family well-being. The program runs for 10 sessions, parallel to the CASA Classroom in the first five months of the program, with two post-group check-ins for the duration of the program. Sessions address the parent-child relationship, strengthening parenting skills and building understanding of adolescent development and diagnosis.

CASA Mental Health Classrooms follows an evidence-informed, trauma-informed and strengths-based framework designed to take a comprehensive approach to understanding the unique mental health needs of children and adolescents. CASA Mental Health Classrooms is a medically integrated, recovery focused school-based mental health program supported by a team of mental health professionals, a specialized teacher and support staff. With programs being located within the schools we are able to reduce barriers to care, promote a comprehensive, multi-sector approach to mental health recovery, resilience and healthy family function.

### **The clinical approach emphasizes:**

- Diagnostic clarification and medication stabilization;
- Building resilience through individualized, evidence-informed interventions utilizing a therapeutic milieu approach;
- Fostering positive coping, communication, and relational skills; and
- Promoting supported and intentional transition back to community and school environments.

## What Happens in the Program

Youth and families participate in a structured program that integrates therapy, education and family-based

supports. Treatment includes individual, group and other therapy modalities that build emotional regulation, understanding of diagnosis, coping skills and relational capacity. The CASA Mental Health Classroom environment focuses on social and life skills, positive coping, self esteem and school engagement.

The Classrooms team works to develop treatment and programming tailored to the student's mental health and learning needs. This includes collaborative goal setting with patients and their caregivers. Short-term program outcomes include a better understanding of the student's diagnosis, a reduction in symptoms and an increase in the student's mental health management skills.

Classroom cohorts are semester-based, with five months of a school year in a CASA Mental Health Classroom, starting in September or February, followed by five months of transition support into community services and parenting support.

## Treatments and Program Includes

- Comprehensive mental health assessment;
- Individualized treatment plan;
- Individual and group therapy;
- Experiential therapies and groups;
- Medical care, medication stabilization and diagnostic clarity;
- Individualized academic instruction;
- Referrals to relevant community and social supports;
- Robust transition process with a transition back to their medical provider and supported strategic school reintegration; and
- Caregiver/guardian psychoeducation and targeted group programming.

## Who Provides Care

The CASA Mental Health Classrooms multidisciplinary team includes: a school division provided teacher; CASA therapy support assistants; CASA mental health therapists; a CASA mental health nurse; CASA therapy support navigators for transition support; where possible, a specialized physician with training in mental illness management to consult; and access to alternate multi-disciplinary team members such as OT and SLP therapists in varying forms depending on the area. We also have a leadership team made up of a program manager, clinical program supervisor and a program education lead.

In partnership with local school divisions who provide the classroom and certified teachers, CASA provides the healthcare team to deliver an integrated recovery-focused mental health treatment and educational support program.

The classroom team works to develop treatment and programming tailored to the student's mental health and learning needs. This includes collaborative goal setting with patients and their caregivers, as well as building capacity in the patients, caregivers and other supportive adults (school, health care providers, community providers).

## How the Program Connects to Other Services

CASA Mental Health Classrooms functions within a broader continuum of care, coordinating with schools, parents and community services to ensure smooth transitions and cross service collaboration and connection. We strive to understand and connect to each individual community so that we can understand what is existing and available and begin to build connection and collaborative opportunities.

CASA Mental Health Classrooms are part of the provincial child and youth mental health services continuum of care designed to provide treatment to children and adolescents in the least restrictive environment possible. This recognizes the need for safety, with the minimum possible disruption to their family, education, social and community networks.

## Step-up and Step-down Services While in Programming

CASA Mental Health Classrooms is a step-up from mental health supports which are typically available in the school and community settings. Referral to CASA Mental Health Classrooms requires previous access to school or community level mental health supports which may have not been as successful as hoped, or where mental

illness may restrict the efficacy of attempted supports.

For youth who may require further supports or a step-up in services which are beyond those available in CASA Mental Health Classrooms, referrals will be supported to more intensive interventions (e.g. acute risk, family crisis). Potential referrals are based on location, history of previous services, as well as the results from the assessments conducted in the early stages of the Classrooms program.

Youth demonstrating improved stability, lower risk or readiness for school and community reintegration may step down or transition to less intensive services or outpatient supports. These flexible transitions ensure continuity of care and alignment with each youth's evolving needs.

## How We Support Transitions

Transition support staff collaborate with the multidisciplinary team to provide proactive, post-treatment coordination before and after discharge. Transition planning begins at the time of referral with intentional and planned connections with referring school and providers, collaborative goal setting and ongoing support for the student while they are in the CASA Mental Health Classroom and as they transition back to their community supports. Families are engaged to co-create a transition plan that addresses community, school, social and health-care needs.

As part of the first five months, the CASA Mental Health Classroom treatment team works with the "home," or referring, school and other community resources to talk about how the student will be coming back to their care. This includes intentional connections in various forms throughout the semester and, where possible, visits back to the school for important events. As the first semester draws to a close, the student may spend a day or more back at their home school to begin that transition process. During the second five months, patients - as well as receiving school staff - are supported by the CASA Mental Health Classroom transition team in a five-month integrated transition process. Patients are supported in a return to school with the goal of implementing strategies and practices which were found to be helpful in the CASA Mental Health Classrooms setting.

Receiving school staff are also supported through modelling, consulting, professional development and planning how best to support each patient in their school setting. Over the course of the five-month supported transition period, receiving school staff and community-based mental health supports are increasingly relied on to act as a support network for the patient. Wherever possible, if a community resource is identified as needed for the student or family, the classroom team will try to facilitate a warm handoff and ensure the appropriate information is made available to that resource.

In addition to the patient support in CASA Mental Health Classrooms, patients' families are supported with a range of psychoeducational programming, access to mental health professionals, encouragement and personal connection, with the primary goal of supporting families' continued engagement in required community services.

## How We Measure Success

The CASA Mental Health Classrooms program outcomes demonstrate improved clinical stability, family function and reintegration success. Short-term program outcomes include a better understanding of the student's diagnosis, a reduction in symptoms and an increase in the student's mental health management skills. We utilize a number of standardized and self/family reported measures.

### **A few examples of CASA Mental Health Classrooms outcomes are:**

- Academic achievement;
- Improved school attendance and participation;
- Improvements in social functioning;
- Mental health diagnostic clarity and symptom reduction; and
- Increased family coping and decreased family stress.

## Target Patient and Family Volume by Location (total seats available)

**As of February 2026:** Calgary (72), Central (156), Edmonton (216), NE (72), NW (36), South (96)

**September 2026 will add:** Five Classrooms, NE- Lloydminster (24 seats), Edmonton-St Albert (24 seats), Pembina Hills (24 seats), Calgary FrancoSud (24 seats), NW - Grande Cache/Edson (24 seats)

- The projections below start from: September 2026 to August 2027; September 2027 to August 2028; September 2028 to August 2029; and are cumulative from September 2025 to August 2026 to reflect the school year versus the fiscal year.
- Patient and family totals are the same patient.
- Total numbers in 2029 = 1,296 seats available.

### Total

	2026-27	2027-28	2028-29
<b>Patients</b>	840	1104	1296
<b>Families</b>	840	1104	1296

### North East

	2026-27	2027-28	2028-29
<b>Patients</b>	72	120	144
<b>Families</b>	72	120	144

### North West

	2026-27	2027-28	2028-29
<b>Patients</b>	96	120	144
<b>Families</b>	96	120	144

### Edmonton

	2026-27	2027-28	2028-29
<b>Patients</b>	240	264	264
<b>Families</b>	240	264	264

### Central

	2026-27	2027-28	2028-29
<b>Patients</b>	192	240	288
<b>Families</b>	192	240	288

### Calgary

	2026-27	2027-28	2028-29
<b>Patients</b>	144	216	264
<b>Families</b>	144	216	264

### South

	2026-27	2027-28	2028-29
<b>Patients</b>	96	144	192
<b>Families</b>	96	144	192

## Total CASA Classrooms Budget and Positions

<b>Total 2026-2027 CASA Classrooms Budget</b>	
<b>Expenses</b>	
Salaries	13,762,999
Benefits	2,752,600
<b>Total Salaries and Employee Benefits</b>	<b>16,515,599</b>
Child & Family Supports	5,000
Program Materials & Supplies	125,000
Education, Conferences & Workshops	275,260
Team Building	16,600
Travel & Subsistence	284,000
Clinical Travel	40,000
Clinical Consultation	489,725
Clinical Contracts / Services	80,000
Office Materials & Supplies	61,000
Other Services & Rentals	3,500
<b>Total Program Expenses</b>	<b>1,380,085</b>
<b>Total Expenses</b>	<b>17,895,684</b>

<b>Position Name</b>	<b>FTE</b>
Assessment Psychologist	2.00
Indigenous Professional Practice Lead	4.00
Indigenous Wellness Support Worker	1.00
Indigenous Wellness Worker	8.00
Mental Health Consultant	0.80
Mental Health Nurse	14.00
Mental Health Therapist	34.60
Mental Health Therapist	1.00
Occupational Therapist	1.40
Professional Practice Lead, Clinical	1.00
Program Administration	1.00
Rehab Assistant	0.80
Speech Language Pathologist	1.40
Therapy Support Assistant	37.00
Therapy Support Navigator	23.00
Program Manager	6.00
Program Education Lead	8.00
Program Supervisor	9.00
Program Supervisor	1.00
<b>Grand Total</b>	<b>155.00</b>

## North

<b>2026-2027 Budget</b>	
<b>Expenses</b>	
Salaries	3,251,985
Benefits	650,397
<b>Total Salaries and Employee Benefits</b>	<b>3,902,382</b>
Child & Family Supports	2,000
Program Materials & Supplies	20,000
Education, Conferences & Workshops	65,040
Team Building	3,900
Travel & Subsistence	100,000
Clinical Consultation	16,533
Office Materials & Supplies	3,500
<b>Total Program Expenses</b>	<b>210,973</b>
<b>Total Expenses</b>	<b>4,113,354</b>

<b>Position Name</b>	<b>FTE</b>
Assessment Psychologist	1.00
Indigenous Professional Practice Lead	2.00
Mental Health Nurse	5.00
Mental Health Therapist	6.00
Program Administration	0.50
Therapy Support Assistant	6.00
Therapy Support Navigator	6.00
Indigenous Wellness Worker	4.00
Occupational Therapist	0.20
Speech Language Pathologist	0.20
Program Manager	2.00
Program Education Lead	2.00
Program Supervisor	2.00
<b>Grand Total</b>	<b>36.90</b>

## Edmonton

<b>2026-2027 Budget</b>	
<b>Expenses</b>	
Salaries	3,359,393
Benefits	671,879
<b>Total Salaries and Employee Benefits</b>	<b>4,031,272</b>
Program Materials & Supplies	45,000
Education, Conferences & Workshops	67,188

Team Building	4,000
Travel & Subsistence	25,000
Clinical Travel	10,000
Clinical Consultation	118,298
Clinical Contracts / Services	40,000
Office Materials & Supplies	14,000
Other Services & Rentals	3,500
<b>Total Program Expenses</b>	<b>326,986</b>
<b>Total Expenses</b>	<b>4,358,258</b>

<b>Position Name</b>	<b>FTE</b>
Mental Health Nurse	3.00
Mental Health Therapist	10.60
Occupational Therapist	0.60
Rehab Assistant	0.80
Therapy Support Assistant	12.00
Therapy Support Navigator	5.00
Indigenous Wellness Worker	1.00
Speech Language Pathologist	0.60
Program Manager	1.00
Program Education Lead	2.00
Program Supervisor	2.00
<b>Grand Total</b>	<b>38.60</b>

## Central

### 2026-2027 Budget

#### Expenses

Salaries	3,036,061
Benefits	607,212
<b>Total Salaries and Employee Benefits</b>	<b>3,643,273</b>
Program Materials & Supplies	25,000
Education, Conferences & Workshops	60,721
Team Building	3,600
Travel & Subsistence	75,000
Clinical Travel	10,000
Clinical Consultation	118,298
Clinical Contracts / Services	30,000
Office Materials & Supplies	9,000
<b>Total Program Expenses</b>	<b>331,619</b>
<b>Total Expenses</b>	<b>3,974,892</b>

<b>Position Name</b>	<b>FTE</b>
Assessment Psychologist	0.50
Indigenous Professional Practice Lead	1.00
Mental Health Nurse	3.00
Mental Health Therapist	8.00
Occupational Therapist	0.20
Speech Language Pathologist	0.20
Therapy Support Assistant	8.00
Therapy Support Navigator	5.00
Indigenous Wellness Worker	2.00
Program Manager	1.00
Program Supervisor	3.00
Program Education Lead	2.00
<b>Grand Total</b>	<b>33.90</b>

## Calgary

<b>2026-2027 Budget</b>	
<b>Expenses</b>	
Salaries	2,167,014
Benefits	433,403
<b>Total Salaries and Employee Benefits</b>	<b>2,600,417</b>
Child & Family Supports	3,000
Program Materials & Supplies	20,000
Education, Conferences & Workshops	43,340
Team Building	2,700
Travel & Subsistence	48,000
Clinical Travel	10,000
Clinical Consultation	118,298
Office Materials & Supplies	19,500
<b>Total Program Expenses</b>	<b>264,838</b>
<b>Total Expenses</b>	<b>2,865,255</b>

<b>Position Name</b>	<b>FTE</b>
Indigenous Professional Practice Lead	0.50
Mental Health Consultant	0.80
Mental Health Nurse	2.00
Mental Health Therapist	6.00
Occupational Therapist	0.20
Program Administration	0.50
Speech Language Pathologist	0.20
Therapy Support Assistant	6.00

Therapy Support Navigator	3.00
Indigenous Wellness Worker	1.00
Program Manager	1.00
Program Supervisor	2.00
Program Education Lead	1.00
<b>Grand Total</b>	<b>24.20</b>

## South

### 2026-2027 Budget

#### Expenses

Salaries	1,948,546
Benefits	389,709
<b>Total Salaries and Employee Benefits</b>	<b>2,338,255</b>
Program Materials & Supplies	15,000
Education, Conferences & Workshops	38,971
Team Building	2,400
Travel & Subsistence	36,000
Clinical Travel	10,000
Clinical Consultation	118,298
Clinical Contracts / Services	10,000
Office Materials & Supplies	15,000
<b>Total Program Expenses</b>	<b>245,669</b>
<b>Total Expenses</b>	<b>2,583,924</b>

<b>Position Name</b>	<b>FTE</b>
Assessment Psychologist	0.50
Indigenous Professional Practice Lead	0.50
Indigenous Wellness Support Worker	1.00
Mental Health Nurse	1.00
Mental Health Therapist	5.00
Occupational Therapist	0.20
Professional Practice Lead, Clinical	1.00
Speech Language Pathologist	0.20
Therapy Support Assistant	5.00
Therapy Support Navigator	4.00
Program Manager	1.00
Program Supervisor	1.00
Program Education Lead	1.00
<b>Grand Total</b>	<b>21.40</b>

# Children's Day Program

## Who we serve

The Children's Day Program (CDP) is a tertiary-level, interdisciplinary diagnostic and therapeutic resource for children in grades 3 to 6 experiencing severe challenges regulating their emotions and behaviour. These challenges have impacted their ability to participate meaningfully in home, school and community environments. Children attending the program may also have associated difficulties with executive function in the domains of attention, impulse control, planning, judgment, cognitive flexibility or learning disabilities. The program provides assessment, diagnosis, therapy and medication review to children at a CALOCUS level four.

## How we help

CDP's goal is to help children and their families develop skills to enable them to experience increased success in school, peer relationships and within the family. Patients attend every school day for an average of one semester (4.5 months), which allows for two intake periods per year in September and February.

Children and families receive comprehensive assessment, medication stabilization and evidence-informed family and group psychotherapy focused on improved functioning. Caregiver group therapy helps to address the caregiver-child relationship, strengthens parenting skills and builds understanding of child development and diagnoses.

A successful return to a community school is a priority. This is achieved by planning for a successful transition together with the family and community school from the beginning of the program, as well as strengthening existing abilities and developing new skills to ensure success.

## What happens in the program

The Children's Day Program follows a trauma-informed and strength-based framework designed to enhance emotional and behavioural regulation, academic learning, social competence and self-worth. In addition, improvements in the ability of home and school to support the child's development and learning are key outcomes of CDP.

### **The clinical approach emphasizes:**

- Diagnostic clarification and medication stabilization;
- Building resilience through individualized, evidence-informed interventions;
- Fostering positive coping, communication and relational skills;
- Improving parental competence and skills in supporting their child; and
- Promoting successful transition back to the community and school environments.

Children and families participate in a structured program that integrates therapy, education and family-based supports within a day treatment setting. Intervention includes individual behaviour therapy embedded in classroom activities, along with group and family therapy modalities that build parenting strategies, coping skills and relational capacity.

### **Therapeutic modalities include:**

- Small group therapy (Stop Now and Plan™, a cognitive-behavioural program);
- Individual family therapy;
- Therapeutic milieu;
- Art therapy;
- Occupational and speech therapy interventions;
- Therapeutic Crisis Intervention;
- Individual behavioural therapy within the classroom context; and
- A 10-week parent group (a mandatory component of the program).

The core evidence-based treatment for children, Stop Now and Plan (SNAP)<sup>™</sup>, and its associated SNAP Parenting Group use a cognitive-behavioral approach involving goal setting, cognitive restructuring, modeling, role-playing, feedback and home practice. Repeated practice across topics relevant to children referred to CDP—such as stealing, lying and social interactions—promotes generalization beyond the treatment setting and helps children develop self-regulation and problem-solving skills.

## Who provides care

The CDP team includes teachers, mental health therapists, behavioural specialists, psychiatrists, nurses, therapy support assistants, assessment psychologists, occupational and speech therapy, and therapy support navigators. The interprofessional team meets bi-weekly to discuss patients’ assessments, goals and progress in treatment. Outcomes focus on addressing skill deficits identified by assessments across disciplines, and ongoing changes to the treatment goals are made as indicated by data collected daily by the team.

## How the program connects to other services and supports transitions

The Children’s Day Program functions within a broader continuum of care, coordinating with community-based services to ensure smooth transitions. During a patient’s treatment in the program, the interdisciplinary team may determine, in conjunction with the family, that a different level of service is required.

A step-up service may be recommended if there is severe aggression that cannot be managed in a day program setting, aggression that has endangered the safety of other children and/or if a patient presents with increasing acuity in suicidal ideation or self-harm during treatment.

CDP may be a step-down service from higher acuity programming, as a halfway point from intensive inpatient care before transition to the community school.

CDP students can also step down to CASA Classrooms to support further skill development and generalization before transition to the community school.

These flexible transitions ensure continuity of care and alignment with each child’s evolving needs.

Transition support staff collaborate with the multidisciplinary team to provide proactive, post-treatment coordination before and after discharge. Families are engaged to co-create a transition plan that addresses community, school and health-care needs. Community mental health providers, along with community schools and parents, are invited to a comprehensive transition meeting at discharge that outlines effective interventions, assessment results and strategies suggested for continuation within the home, school and community settings.

Non-urgent, follow-up transition support is provided for a defined period after discharge, typically for another full semester. This support can include community visits, school observations and meetings, and connections to mental health-care and services within the community.

## How we measure success

Program outcomes are demonstrated by improved clinical stability, overall family functioning and successful transitions back to school and community.

### The Children’s Day Program tracks outcomes such as:

- Diagnostic clarity and symptom reduction;
- School attendance, participation and performance;
- Emotional regulation and social skills;
- Parenting stress;
- Caregiver satisfaction; and
- Warm hand-offs to community-based service providers.

## Target patient and family volume by location

### Edmonton

	2026-27	2027-28	2028-29
<b>Patients</b>	24	24	24
<b>Families</b>	24	24	24

## 2026-2027 Budget

### Expenses

Salaries	853,358
Benefits	170,672
<b>Total Salaries and Employee Benefits</b>	<b>1,024,030</b>
Recreation	1,200
Child & Family Supports	1,500
Program Materials & Supplies	10,000
Education, Conferences & Workshops	17,067
Team Building	1,020
Travel & Subsistence	2,000
Clinical Consultation	23,880
Clinical Contracts / Services	5,373
Office Materials & Supplies	2,000
Memberships & Dues	6,500
<b>Total Program Expenses</b>	<b>70,540</b>
<b>Total Expenses</b>	<b>1,094,570</b>

### Position Name

Assessment Psychologist	0.35
Behavioural Specialist	1.00
Mental Health Therapist	1.00
Occupational Therapist	0.40
Occupational Therapy Assistant	0.50
Program Manager, Day Programs	0.33
Speech Language Assistant	0.25
Speech Language Pathologist	0.40
Therapy Support Assistant	4.00
Therapy Support Navigator	0.66
Mental Health Nurse	0.50
Program Supervisor	0.66

### Grand Total

**10.05**

# Clinical Administration

## Who we serve

Clinical Administration provides support both to patients and families, and to internal CASA programs and services. We are involved in every program at CASA that provides mental health care to children, youth and families.

We directly serve children, youth and families by providing reception, navigation assistance, appointment support, and communication throughout their care journey.

We also support clinical and program teams across Core, Day Programs, Family Program, Trauma Programs (Edmonton and Calgary), Classroom Programs, Psychological Assessment and Consultation Services, Psychiatry and Medical Clinics and CASA House. We collaborate with interdisciplinary teams including therapists, physicians, nurses, behaviour specialists, family support workers, care coordinators, program managers, Indigenous Services and Philanthropy.

We also work closely with internal CASA departments such as Triage, Navigation and Transition Services, Business Intelligence and Evaluation, Privacy and Health Information Management, Information Technology, People and Culture, Finance, Facilities and Communications.

## How we help

Clinical Administration provides direct support to families and operational support to clinical teams, ensuring coordinated, accessible, safe and consistent program delivery. We are the warm and welcoming faces that are one of the first points of contact for most CASA Mental Health patients and families. By being consistently present for our youth and families, we help to introduce patients into a trauma-informed, supportive journey through our programs and services.

We help families by greeting them, checking them in, providing directions, answering questions, scheduling appointments, sending reminders and helping them prepare for program expectations. In this way, we are an integral part of family engagement.

We help clinical teams by coordinating schedules, booking appointments and groups, managing program calendars, supporting documentation, preparing clinic flow, maintaining room bookings, assisting with onboarding, and supporting group and classroom logistics. This allows our health care professionals to provide smooth and seamless services, reducing barriers to access and ongoing engagement.

Families interact with Clinical Administration throughout their program involvement, ranging from short-term to long-term engagement depending on program type. We meet our families where they are and in the ways they prefer to communicate: in person at CASA sites, by phone, email, virtual platforms and across community and school-based settings.

## What happens in the service

Clinical Administration manages the daily operational tasks that enable clinical programs to function smoothly.

This includes reception duties, call management, scheduling appointments and assessments, coordinating group programs, supporting clinicians during clinic flow, maintaining documentation accuracy, preparing program materials, monitoring program attendance, facilitating measurement of outcomes and satisfaction, and coordinating transitions between programs.

## Who provides care

Clinical care is provided by an interprofessional team consisting of physicians, therapists, nurses, behaviour specialists, family support workers, care coordinators and program managers.

Clinical Administration works alongside these disciplines to ensure families receive timely, organized, and well-supported care through coordinated communication, scheduling and documentation support. This aligns CASA Mental Health with best practices for trauma-informed care, as well as family and community engagement.

## How the service connects to other programs/services

Clinical Administration connects families across programs and services throughout their care journey.

We coordinate transitions between all clinical programs. We also work with Triage, Navigation and Transition Services for intake movement, with Privacy and Health Information Management for secure documentation, with Business Intelligence and Evaluation for accurate data, with Indigenous Services for culturally safe coordination, with Philanthropy for donor-supported initiatives, and with Information Technology and Facilities for safe and functional operations.

We support discharge planning, follow-up appointments, document distribution and communication with schools and community supports when directed by clinicians.

## How we measure success

Success is measured through family experience, operational accuracy and program flow indicators.

Key measures include accuracy and timeliness of scheduling, clarity and responsiveness of communication, smooth clinic flow, reduced missed appointments, documentation completeness, consistency across sites, clinician satisfaction and the ability to support program capacity.

Evaluation occurs through feedback, operational metrics, documentation review and system monitoring.

### 2026-2027 Budget

#### Expenses

Salaries	1,058,672
Salaries - Casuals	133,000
Benefits	211,734
<b>Total Salaries and Employee Benefits</b>	<b>1,403,406</b>
Program Materials & Supplies	665
Education, Conferences & Workshops	23,833
Team Building	3,300
Travel & Subsistence	5,000
Office Materials & Supplies	26,000
<b>Total Program Expenses</b>	<b>58,798</b>
<b>Total Expenses</b>	<b>1,462,205</b>

#### Position Name

	<b>FTE</b>
Administrative Assistant	1.00
Manager, Clinical Administration	1.00
Reception	7.70
Physician Support Specialist	3.00
Program Support Specialist	7.00
<b>Grand Total</b>	<b>19.70</b>

# Clinical Pathways

## Who we serve

Clinical Pathways is a supportive program designed to ensure CASA programs and services, staff, leadership and community partners understand and work towards better positioning CASA services within the broader continuum of health care for each patient and their family. Understanding and making processes simpler for intake, internal referral and external referral is built through procedures and community relationship building. The intent is not front-line navigation; rather, it is to assist with organizational positioning and processes.

## How we help

The Pathways team meets with program and community leaders across the province to determine their current level of community engagement and helps to develop a plan for local leadership and program teams to better position their program within the continuum of care.

The Pathways team can be accessed at any time to assist with community relationship building, presentations to partners and brainstorming possibilities when faced with barriers or difficulties navigating the broader mental health and social support system.

The Pathways team acts as liaison for province-wide supports such as 211 and Kickstand.

If your team is struggling with navigating the mental health system when you have patients and families that need to step up or step down in programming, please access the request form on the intranet [here](#).

## What happens in the service

The Pathways team meets with CASA leaders to create the process, plan and implementation of community engagement. How much direct support is provided will vary depending on community needs, current relationships within the community or other variables.

By working together with CASA staff and engaging in relationship building ahead of expansion, CASA can ensure long-standing collaborative partners in the mental health journeys of patients, with the intention of sustainable and long-term supports for both patients and families. By understanding which programs and services are available, barriers and gaps in services can be identified and mitigated as much as possible. Program outputs consist of community support matrices and development plans co-created with local leaders.

Broader outcomes would include local teams being able to identify and use their community relationships to have better outcomes for patients and families, ease of referrals and processes in place.

Internal and external pathways will be located on OneDrive, with each program having their own deliberate community network. Local program teams will be responsible for maintaining their community partner networks, with assistance on creation from the Pathways team when necessary.

## How we measure success

The long-term goals for this program are to increase patient throughput, decrease recidivism and ensure more successful referrals and wraparound processes for patients and families.

Exact measures beyond quantitative totals are yet to be determined and will be developed with the Business Intelligence team as Pathways develops. Given we haven't determined exact measures, it is difficult to predict target measures. Ideally, local teams will be able to have their community relationship plans and targets and success can be measured by their use and implementation.

Children, youth and their families will experience fewer barriers to services and smoother transitions to, through and from services when programs work together. Pathways will support local teams and their school and community partners to develop, map and facilitate those connections.

## 2026-2027 Budget

### Expenses

Salaries	303,190
Benefits	60,638
<b>Total Salaries and Employee Benefits</b>	<b>363,828</b>
Program Materials & Supplies	1,000
Education, Conferences & Workshops	6,064
Team Building	300
Travel & Subsistence	10,000
Office Materials & Supplies	2,000
<b>Total Program Expenses</b>	<b>19,364</b>
<b>Total Expenses</b>	<b>383,191</b>

### Position Name

	<b>FTE</b>
Clinical Pathway Specialist	2.00
Manager, Pathways	1.00
<b>Grand Total</b>	<b>3.00</b>



# Core

## Who we serve

The CASA Core program provides mental health services for children and youth aged three to 17 who are experiencing mental illness. Treatment is goal-oriented, voluntary and community-based. The program is designed to promote mental well-being by providing an integrated bio-psycho-social approach to mental health assessment, treatment, consultation and referral services to appropriate community supports.

## How we help

Core services are provided by an interprofessional team including psychiatrists, social workers, psychologists, occupational therapists, speech and language pathologists and nurses. Together, these registered professionals employ a multi-faceted blend of therapeutic modalities to facilitate the healing and growth of patients and their families. Therapeutic modalities include:

- Individual therapy - may include play-based and expressive arts approaches;
- Cognitive-Behavioural Therapy (CBT);
- Dialectical Behaviour Therapy (DBT) - informed;
- Dyadic interventions;
- Group therapy; and
- Educational sessions for caregivers.

The Core program recognizes that child and youth mental health develops in the context of relationships, and the Core program aims to support healthy relationships around the child or youth, including with the parent/caregiver, family and community. The Core team aims to promote the healthy development of the child, identify strengths and struggles, reduce the symptoms of mental illness, and provide information and strategies to the child and their caregivers that facilitate growth. Core is committed to providing evidence-informed, patient-centered, strength- and relationship-based approaches to mental health interventions that are sensitive and responsive to the diverse experiences of families. Treatment services are always provided within the framework of best practice.

Consultative Services: Within the Core program, we provide consultative services to Children and Family Services, Home Visitation and Head Start service providers in the community who are working with children age five and under. Core professionals provide consultation for individual children who are presenting with mental illness and their families, as well as general consultative services for a variety of children's mental health-related concerns. Core also provides capacity-building and support for staff from these organizations. When more intensive services are required, Core provides a direct pathway into clinical services and these children may connect with a mental health therapist for assessment and treatment.

## What happens in the program

The Core program aims to deliver the highest quality of mental health care that:

- Provides timely and flexible access to mental health care;
- Matches clinical presentation of the child/youth and their family with the appropriate level of clinical service, while acknowledging that clients may need to step up or step down in levels of care;
- Provides a range of service streams that address common problem presentations and provide multiple pathways of care, using the least intensive levels of services first;
- Delivers mental health care programming that is efficient, sustainable and accountable;
- Redirects referrals when appropriate to other CASA specialized programs in order to ensure families are matched with the right service at the right time;
- Offers active inclusion/participation of the family in treatment; and
- Provides inclusion of the school and community network of the child and family to provide a holistic approach.

## Who provides care

The CASA Core interprofessional team includes: psychiatrists, social workers, psychologists, occupational therapists, speech and language pathologists and nurses.

## How the program connects to other services and supports transitions

During a patient's treatment in the program, the interprofessional team may determine, in conjunction with the family, that a different level or step up in services is required. Other programs such as CASA House, a day program, Family or Trauma services may be accessed if a more intensive service is required.

Step-down services from the program may be appropriate when a patient and their family has completed their course of care and less intensive supports are required. The staff in our program may then work to connect the patient and family to community programs to build their natural support network.

## How we measure success

Program outcomes demonstrate reduction in adverse symptoms, improvement in daily functioning and improvement in overall mental health. Patient satisfaction is measured based on voluntary survey completion at discharge from care.

## Target patient and family volume by location

2024-25	2025-26	2026-27
1,000	1,000	1,000

## 2026-2027 Budget

### Expenses

Salaries	3,247,933
Benefits	649,587
<b>Total Salaries and Employee Benefits</b>	<b>3,897,519</b>
Child & Family Supports	11,000
Program Materials & Supplies	11,599
Education, Conferences & Workshops	64,959
Team Building	3,700
Travel & Subsistence	9,000
Clinical Consultation	100,000
Office Materials & Supplies	2,000
Software & Subscription	3,000
<b>Total Program Expenses</b>	<b>205,258</b>
<b>Total Expenses</b>	<b>4,102,777</b>

### Position Name

Position Name	FTE
Concurrent Counsellor	2.00
Mental Health Therapist	19.20
Occupational Therapist	1.00
Therapy Support Navigator	7.80
Program Supervisor	2.90

Program Manager	1.00
Speech Language Pathologist	0.60
<b>Grand Total</b>	<b>34.50</b>



# Family Therapy

## Who we serve

The CASA Family Therapy Program provides voluntary, community-based family therapy services for families of index patients between the ages of three to 17 who are experiencing mental illness with a CALOCUS level of 3 to 4. CALOCUS levels of 4 are only supported provided that an individual therapy program is also providing support for the family in tandem.

## How we can help

The program views the familial relationship as the “patient” and is designed to enhance family functioning, address parenting blocks, improve caregiver competencies in parenting and raising children with a mental illness, and boost communication and connection between all family members in service of the recovery and healing of the index patient. Our framework focuses on the following key areas:

- Delivering family-centred and trauma-informed care with the familial relationship as the patient;
- Strength-based: Highlighting and nurturing existing strengths within the family to help family members understand and support each other and to shift any unhealthy relational patterns;
- Building skills and enhancing caregiver capacities to raise children living with a mental illness; and
- Nurturing healthy attachment between caregiver and their child.

## What happens in the program

Family Therapy sessions may include couples’ counselling to enhance co-parenting relationships, caregiver-child focused therapy to build attachment and connection between caregivers and the child, or family therapy sessions for the whole family system depending on the patients’ needs, goals and therapy progress.

Connect Parenting Groups may be offered to caregivers to build attachment-focused parental capacity and to enhance parental skills.

Throughout the course of therapy, therapists complete an assessment of family functioning. Family therapy goals are established in collaboration with family members, and a family treatment plan is created.

Depending on the treatment goals and family needs, individual therapy for the youth and/or adult family members in the family system may be required or recommended to occur in tandem with family therapy.

## Who provides care

The Family Therapy Interprofessional team includes mental health therapists, adult and child psychiatrists, a concurrent counsellor and a therapy support navigator. Together, the team employs a multi-faceted blend of therapeutic modalities to facilitate the healing and growth of families. Therapeutic modalities include:

- Family therapy/Co-therapy:
  - Attachment-focused family therapy/dyadic developmental psychotherapy;
  - Emotionally-focused family therapy/emotionally-focused therapy;
  - Emotion-focused family therapy;
  - Narrative therapy;
  - The Gottman Method;
  - Play based modalities (e.g., attachment-focused play, sand tray therapy).
- Reflecting teams:
  - In this model, family therapy sessions are conducted with one or more clinicians providing direct intervention while additional clinicians observe from behind a one-way mirror. Following the session, the observing clinicians engage in a reflective discussion about their observations, insights and hypotheses. The family then observes this reflective conversation, offering a unique perspective that can enhance self-awareness, deepen understanding and promote collaborative meaning-making within the therapeutic process.

## How the program connects to other services and supports transitions

During a patient's treatment in the program, the multidisciplinary team may determine, in conjunction with the family, that concurrent therapy may be needed in parallel to family therapy involvement. In such cases, the team will support the family to seek a referral to individual therapy for the index patient or make a referral for adult mental health for caregivers as appropriate.

If the care team determines that the index patient requires a stepped-up level of care, the care team will connect with the index patient's primary mental health provider or primary physician to advocate for a referral to the higher level program.

Upon the completion of a course of care, families will be transferred back to their primary care mental health provider or discharged into the community if continued individual therapy is not appropriate. The therapy support navigator in our program may work to connect the index patient and their family to community programming that builds on their natural and formal support networks.

## How we measure success

Program outcomes demonstrate improved family functioning, achievement of family therapy goals, increase in parental reflective functioning and decrease in parental stress.

## Target patient and family volume by location

	2026-27	2027-28	2028-29
<b>Patients</b>	365	365	365
<b>Family Members</b>	512	512	512

### 2026-2027 Budget

#### Expenses

Salaries	903,005
Benefits	180,601
<b>Total Salaries and Employee Benefits</b>	<b>1,083,605</b>
Child & Family Supports	2,000
Program Materials & Supplies	4,000
Education, Conferences & Workshops	18,060
Team Building	1,000
Travel & Subsistence	1,004
Clinical Consultation	17,280
Clinical Contracts / Services	10,000
Office Materials & Supplies	1,000
Other Services & Rentals	2,000
<b>Total Program Expenses</b>	<b>56,344</b>
<b>Total Expenses</b>	<b>1,139,950</b>

#### Position Name

Concurrent Counsellor

**FTE**

0.50

Mental Health Therapist	6.70
Therapy Support Navigator	1.00
Program Manager	0.50
Program Supervisor	0.80
<b>Grand Total</b>	<b>9.50</b>



# Fetal Alcohol Spectrum Treatment Resources and Community Support (FASTRACS)

## Who we serve

FASTRACS provides support to caregivers of children and adolescents ages three to 17 where there is a possible or confirmed diagnosis of Fetal Alcohol Spectrum Disorder (FASD).

## How we help

FASTRACS provides caregivers with an increased understanding of FASD, practical skills and individualized strategies needed to support their child's development, strengthen daily routines, increase stability and improve overall family well-being. The program provides short-term relationship-based education emphasizing positive caregiver and child interaction, and supports the concurrent mental health needs of the child/adolescent. Caregivers receive support in navigating health, mental health, school and community systems, and are connected to relevant resources and services.

## What happens in the program

FASTRACS follows an evidence-informed and strengths-based framework that supports caregivers to manage their child's disability from a rehabilitation and mental health approach. The program includes six weeks of FASD education, parent skills training and individualized strategies to improve the continuity of care across home, school and community environments. The program provides caregiver peer support and guided discussions that strengthen connection, reduce isolation and promote shared learning. To reduce barriers to access, the program offers virtual and in-person group options supported by individual consultations as needed.

Our framework is evidence-informed and focused on three key areas:

1. Application of current FASD research;
2. Effective learning strategies for caregivers to build success across home, school and community; and
3. Reducing toxic stress for children through building upon strengths individually, within the family setting and larger community.

Caregivers participate in a structured program focused on increasing awareness and positive parenting. The program is delivered across six sessions and focuses on:

- FASD education;
- Daily routines and structure;
- Indicators of sensory need;
- Social-emotional learning with a focus on self-management, self-awareness, regulation, behaviour and executive functioning;
- Safety and boundaries; and
- Attachment and caregiver interaction.

Therapeutic interventions include:

- Caregiver management, education and training;
- Child-parent relational therapy approaches; and
- Theraplay-based approaches.

## Who provides care

FASTRACS caregiver education, programming and service navigation is provided by the FASD educator and supported by a family liaison. Consultation with psychiatry is available as required.

## How the program connects to other services and supports transitions

FASTRACS functions within a broader continuum of care, coordinating with internal CASA programs, regional mental health services or community-based services to ensure clients and their families are connected to the right services.

- **Step-up/step-down care:** The program provides step-up and step-down care by ensuring clients receive the right level of support based on their child's needs. Should more intensive clinical mental health services be required the FASD educator will complete the necessary referrals (such as CASA day programs, Trauma and Attachment programming, Family Therapy, CASA House or externally medically-managed 24-hour secure services with psychiatric management) and provide step-down transitional support to regional mental health services, school or community-based supports as needed. To ensure families receive the correct service, the FASD educator and/or family liaison will complete follow-up check-ins at one and two months after discharge.
- FASTRACS provides professional development training to school staff and service providers to support awareness and build the capacity of others providing care and supporting children and adolescents suspected or diagnosed with FASD.

## How we measure success

The program evaluates impact through metrics such as patient satisfaction, wait times, service navigation and participation in the Edmonton Fetal Alcohol Network survey tools. Outcomes are monitored based on the evaluation framework to ensure effectiveness and responsiveness.

### Target patient and family volume by location clients/caregivers

	2026-27	2027-28	2028-29
<b>Clients</b>	20	35	50
<b>Families</b>	20	35	50

### Professional Development: service providers/school staff

	2026-27	2027-28	2028-29
<b>Service Providers</b>	20	35	50
<b>School Staff</b>	40	100	200

## 2026-2027 Budget

### Expenses

Salaries	257,226
Benefits	51,445
<b>Total Salaries and Employee Benefits</b>	<b>308,672</b>
Child & Family Supports	3,000
Program Materials & Supplies	5,000
Education, Conferences & Workshops	5,145
Team Building	275
Travel & Subsistence	4,000
<b>Total Program Expenses</b>	<b>17,420</b>
<b>Total Expenses</b>	<b>326,091</b>

<b>Position Name</b>	<b>FTE</b>
Manager, Clinical	0.25
Therapy Support Navigator	1.00
Senior Clinical Advisor	0.25
Program Support Lead	0.25
Occupational Therapist	1.00
<b>Grand Total</b>	<b>2.75</b>



# Indigenous Services: Comprehensive School-Based Mental Health

## Who we serve

Comprehensive School-Based Mental Health is an evidence-informed framework developed to support child and adolescent mental health and well-being. The Comprehensive School-Based Mental Health program is delivered in partnership with First Nation and Métis school divisions to provide children and adolescents access to culturally responsive, trauma-informed mental health education and intervention services.

## How we help

Utilizing the Response to Intervention (RTI) model, the program supports school division partners with the development and implementation of a multi-tiered service model of intervention:

- Tier 1 includes the implementation of universal mental health prevention and promotion programming to increase mental health literacy, reduce stigma and promote healthy coping and help seeking behaviours.
- Tier 2 includes providing access to targeted interventions for students identified at elevated risk as a result of capacity building with school staff, further reducing the need for specialized services.
- Tier 3 provides direct access to specialized intervention for those requiring individualized mental health treatment, including access to the Specialized Therapeutic Classroom.

Beyond the development of a comprehensive school-based mental health service model, the Indigenous Services team works with school division partners to support the provision and sustainment of these services.

## What happens in the program

Universal programming and wrap-around mental health services are provided directly in First Nation and Métis schools and are accessible to children across all grade levels. The Specialized Therapeutic Classroom offers intensive mental health assessment and treatment for adolescents in grades 7 through 9. The program takes a two-eyed approach, blending clinical, evidence-informed and trauma-informed practices with Indigenous knowledge, values and ways of healing to ensure all services are culturally grounded, patient-centred, developmentally appropriate and recovery focused. Treatment and services include:

- Comprehensive and culturally informed assessment;
- Diagnostic clarity;
- Individualized treatment;
- Group therapy;
- Psychoeducation;
- Medication reconciliation and management as required;
- Universal mental health prevention programming;
- Social emotional learning/literacy;
- Traditional ceremony, wellness and land-based practices;
- Traditional kinship and parenting models;
- Individualized culturally integrated services;
- Caregiver/guardian psychoeducation and parenting support;
- Other adjunctive therapies when indicated (occupational therapy; speech language pathology);
- Grief and loss counselling;
- Addictions counselling and education;
- Individualized academic instruction;
- Referrals to relevant community and social supports; and
- Professional development with school division administrators, staff and teachers.

Treatment within the program draws on a range of therapeutic modalities tailored to each patient's unique needs and cultural context. These are complemented by culturally grounded and relational healing practices that honour Indigenous worldviews and promote balance in mental, physical, emotional and spiritual wellbeing. This strength-based, integrated approach supports both clinical and cultural pathways to healing, fostering resilience and long-term wellness for children, adolescents, and their families. Therapeutic modalities include:

- Cognitive-Behavioural Therapy (CBT);
- Dialectical Behaviour Therapy (DBT);
- Indigenous Focused Oriented Therapy (IFOT);
- Milieu therapy;
- Trauma therapy;
- Art therapy;
- Narrative therapy;
- Play therapy;
- Somatic experiencing;
- Child-parent relational therapy; and
- Emotionally-focused family therapy.

## Who provides care

The program uses a multidisciplinary staffing model that evolves annually to meet growing service needs. It includes roles such as senior clinical advisor, clinical manager, mental health therapists, wellness coaches, family liaisons (TSNs), therapy support assistants, psychiatry, registered nurses and Elders and Knowledge Keepers. Over the years, staffing levels have increased to support expanded programming, with adjustments made to reflect budget changes and service priorities. Each role contributes to a tiered mental health support system, ensuring culturally responsive, trauma-informed care is delivered directly in First Nation and Métis schools through prevention, intervention and treatment services.

## How the program connects to other services and supports transitions

Services are provided in partner First Nation and Métis schools, with referrals to First Nations Métis and Inuit (FNMI) Mental Health Services or other CASA programs when more intensive mental health intervention is required. A robust transition process supports students through the purposeful tapering of treatment (in both intensity and frequency), strategic school reintegration and guided transitions to aftercare services.

**Step-up/Step-down care:** The program provides step-up and step-down care by ensuring students receive the right level of support based on their needs. Patients can step up to more intensive clinical mental health services when a higher level of intervention is required (such as FNMI Mental Health Services, CASA day programs, Trauma and Attachment programming, Family Therapy, CASA House or externally medically managed 24-hour secure services with psychiatric management) and step down to school or community-based supports as their functioning has improved.

**Sustainable community-based mental health systems:** The Comprehensive School-Based Mental Health program is part of a larger community mental health initiative. This initiative includes a phased approach over a three-year term. The first phase includes the development of collaborative relationships with service providers, community members, Elders and Knowledge Keepers, an environmental scan to identify gaps in care, and implementation of the Comprehensive School-Based Mental Health program. The second phase focuses on addressing service gaps in the community and supporting the continuum of supports in schools. The third phase aims to support the long-term self sustainment of these mental health systems of care.

## How we measure success

The program measures success by tracking outcomes across three tiers of intervention: universal, targeted and specialized. It evaluates impact through metrics such as presentation attendance, patient satisfaction, wait times, mental health status, treatment outcomes, number of community referrals and partnerships, and cultural support access. Program-level success is assessed via community partnerships, resource use and professional development activities. These outcomes are monitored using a dedicated evaluation framework, which includes surveys, clinical assessments, program-level data collection tools to ensure effectiveness, responsiveness, and sustainability of services.

## Target children and adolescents served by tier

The program tracks the number of children served each year across three tiers of programming – Tier 1 (universal), Tier 2 (targeted group programming) and Tier 3 (individualized intervention) – demonstrating progressive growth in both reach and level of support, from broad mental health literacy initiatives to specialized therapeutic care.

### Universal programming-Tier 1

	2026-27	2027-28	2028-29
<b>Children/Adolescents</b>	550	750	900

### Targeted group programming-Tier 2

	2026-27	2027-28	2028-29
<b>Children/Adolescents</b>	30	70	85

### Individualized intervention-Tier 3

	2026-27	2027-28	2028-29
<b>Children/Adolescents</b>	35	70	100

## 2026-2027 Budget

### Expenses

Salaries	926,592
Benefits	185,318
<b>Total Salaries and Employee Benefits</b>	<b>1,111,910</b>
Child & Family Supports	16,000
Program Materials & Supplies	30,000
Education, Conferences & Workshops	18,532
Team Building	1,100
Travel & Subsistence	26,000
Clinical Travel	3,000
Clinical Consultation	17,500
Office Materials & Supplies	4,250
Professional Consulting / Services	5,000
<b>Total Program Expenses</b>	<b>121,382</b>
<b>Total Expenses</b>	<b>1,233,292</b>

### Position Name

### FTE

Manager, Clinical	1.00
Mental Health Therapist	3.00
Therapy Support Assistant	3.00
Wellness Coach	3.00
Senior Clinical Advisor	0.25
Mental Health Nurse	0.50
Program Support Lead	0.25
<b>Grand Total</b>	<b>11.00</b>

# Indigenous Services: First Nation, Métis and Inuit Mental Health Services

## Who we serve

First Nation, Métis and Inuit (FNMI) Mental Health Services is a community-based service that provides trauma-informed and culturally responsive mental health care to Indigenous children, adolescents and their families residing in or members of the Alexander, Alexis Nakota Sioux, Enoch Cree and Paul First Nation communities.

## How we help

First Nation, Métis and Inuit Mental Health Services provides Indigenous-informed, holistic and culturally-responsive mental health care. The multidisciplinary team integrates traditional Indigenous mental health and wellness practices and world views with western approaches to assessment and modalities of treatment. Children, adolescents and their families receive a culturally-informed comprehensive assessment and holistic care plan that informs individualized treatment.

## What happens in the service

First Nation, Métis and Inuit Mental Health Services provides equitable and timely access to quality mental health services for rural First Nation and Métis communities. Recognizing the historical impacts of colonization and the over-representation of Eurocentric world views and values in the mental health care of Indigenous children, adolescents, families and communities, FNMI Mental Health Services has a referral and intake process unique to other CASA Mental Health programs and services. FNMI Mental Health Services provides holistic, culturally responsive mental health care that is evidence-based, trauma-informed and patient and family-centred. Treatment is multi-faceted and clinical services are provided by mental health therapists, nurses and psychiatrists as required, as well as supported by a range of non-clinical staff, concurrent counsellors, therapy support navigators, family liaisons, Elders and Knowledge Keepers. Therapy support navigators support families throughout the engagement, treatment and transition process through: removing barriers to access; providing service and resource navigation; psychoeducation; positive parenting education and support the integration of culture into treatment plans.

Treatment and services include:

- Comprehensive and culturally-informed assessment;
- Individualized treatment;
- Diagnostic clarity;
- Psychoeducation;
- Medication reconciliation and management as required;
- Caregiver/guardian psychoeducation and parenting support;
- Individualized culturally-integrated services;
- Traditional ceremony, wellness and land-based practices;
- Traditional kinship and parenting models;
- Individualized culturally integrated services;
- Caregiver/guardian psychoeducation and parenting support;
- Grief and loss counselling;
- Addictions counselling and education; and
- Referrals to relevant community and social supports.

Treatment draws on a range of therapeutic modalities tailored to each patient’s unique needs and cultural context. These are complemented by culturally-grounded and relational healing practices that honour Indigenous worldviews and promote balance in mental, physical, emotional and spiritual wellbeing. This strength-based, integrated approach supports both clinical and cultural pathways to healing, fostering resilience and long-term wellness for children and families.

**Therapeutic modalities include:**

- Cognitive Behavioural Therapy (CBT);
- Indigenous Focused Oriented Therapy (IFOT);
- Trauma therapy;
- Art therapy;
- Narrative therapy;
- Play therapy;
- Somatic experiencing;
- Child-parent relational therapy; and
- Emotionally Focused Family Therapy.

**Who provides care**

The First Nation, Métis and Inuit Mental Health Services multidisciplinary team includes a senior clinical advisor and clinical manager, mental health therapists, concurrent counsellors, therapy support navigators, family liaisons, Elders and Knowledge Keepers, registered nurses and psychiatrists as required.

**How the service connects to other services and supports transitions**

Services are provided in partner with First Nation and Métis communities or at any CASA Mental Health location when it is preferred by the patient or family. FNMI Mental Health Services functions within a broader continuum of care, coordinating with community or acute services to ensure smooth transitions to internal CASA programs or external services. A robust transition process supports children, adolescents and their families through the purposeful tapering of treatment (in both intensity and frequency) with supported transitions to aftercare services.

- Step-up/step-down care: The program provides step-up and step-down care by ensuring patients receive the right level of support based on their needs. Patients can step up to more intensive clinical mental health services when a higher level of intervention is required (such as CASA day programs, Trauma and Attachment programming, Family Services, CASA House or externally medically-managed 24-hour secure services with psychiatric management) and step down to school or community-based supports as their functioning improves. The patient, family and multidisciplinary team collaboratively create a transition plan that supports the continuity of care. Therapy support navigators provide ongoing transition support and complete check-ins at one and two months after discharge.

**How we measure success**

The program measures success by tracking indicators that demonstrate improved clinical outcomes. It evaluates impact through metrics such as patient satisfaction, wait times, treatment outcomes, mental health status and symptom improvement, number of community referrals, and cultural support access. These outcomes are monitored using a dedicated evaluation framework, which includes surveys, clinical assessments, responsiveness and program-level data collection tools to ensure effectiveness.

**Target patient and family volume by location**

	<b>2026-27</b>	<b>2027-28</b>	<b>2028-29</b>
<b>Patients</b>	60	100	140
<b>Families</b>	60	100	140

## 2026-2027 Budget

### Expenses

Salaries	921,633
Benefits	184,327
<b>Total Salaries and Employee Benefits</b>	<b>1,105,960</b>
Child & Family Supports	9,500
Program Materials & Supplies	20,700
Education, Conferences & Workshops	18,433
Team Building	975
Travel & Subsistence	30,000
Clinical Travel	8,000
Clinical Consultation	15,000
Clinical Contracts / Services	2,000
Office Materials & Supplies	9,000
Other Services & Rentals	1,500
Professional Consulting / Services	3,000
<b>Total Program Expenses</b>	<b>118,108</b>
<b>Total Expenses</b>	<b>1,224,068</b>

### Position Name

Position Name	FTE
Concurrent Counsellor	1.00
Manager, Clinical	0.75
Mental Health Therapist	4.00
Therapy Support Navigator	3.00
Senior Clinical Advisor	0.25
Program Support Lead	0.25
Mental Health Nurse	0.50
<b>Grand Total</b>	<b>9.75</b>

# Indigenous Wellness Support Services

## Who we serve

Indigenous Wellness Support Services (IWSS) supports CASA Mental Health's commitment to truth and reconciliation. IWSS builds the knowledge of CASA staff to inform culturally responsive service provision. The IWSS team works collaboratively with First Nation, Métis and Inuit community partners in a reciprocal relationship of learning to respectfully integrate unique traditional mental health and wellness practices into treatment of Indigenous patients served across the organization.

## How we help

IWSS provides education, training and consultation to CASA staff, partner school divisions and service providers operating in First Nation, Métis and Inuit communities. IWSS is responsible for the ongoing Indigenous-informed cultural competency training integral to the provision of culturally-responsive mental health care provided by the First Nation, Métis and Inuit Services team. IWSS also works collaboratively with multidisciplinary teams serving Indigenous patients to integrate traditional Indigenous mental health and wellness practices and world views with western approaches to assessment and modalities of treatment.

## Reconciliation in action

In response to the 94 calls to action issued by the Truth and Reconciliation Commission, CASA created its own organizational commitments that recognized the need to work collaboratively with First Nation, Métis and Inuit communities to provide Indigenous children, adolescents and their families with culturally-informed mental health care that draws on Indigenous knowledges, worldviews and traditions. In 2022, CASA invested in the development of an Indigenous Wellness Support Services team to provide consultation, education and training to staff, inform programming and services, and ensure Indigenous children, adolescents and their families have access to treatment that honours their identity and traditional approaches to mental health and wellness.

Services are Indigenous-informed, evidence-based and culturally responsive:

- Collective truth and reconciliation;
- Indigenous cultural safety in health care;
- Indigenous epistemologies, traditional ceremony, land-based practices and wellness approaches to holistic mental health care;
- Traditional kinship and parenting models;
- Culturally-informed assessment and treatment planning;
- Individualized culturally-responsive treatment;
- Indigenous Focused Oriented Therapy (IFOT);
- Somatic experiencing;
- Intergenerational trauma and epigenetics;
- Trauma-focused;
- Recovery-oriented; and
- Neurodevelopment: strength and resiliency.

## Consultation, education and training

Through consultation, education and training, IWSS works to increase understanding of First Nation, Métis and Inuit histories, world views, cultures, traditions and wellness practices to support holistic approaches to patient care as an integrated part of their treatment.

## Indigenous informed

IWSS works closely with our provincial Wisdom Committee comprising Elders, Knowledge Keepers, those with lived experience and those we serve from our partner First Nation, Métis and Inuit communities to inform service provision.

## Community investment

IWSS provides consultation services to Indigenous community partners to improve the continuum of child and adolescent mental health care in their First Nation, Métis and Inuit communities. The IWSS Team provides ongoing professional development training to school divisions and service providers to build the capacity of those supporting the mental health and wellness of Indigenous children, adolescents and their families.

## Culturally responsive treatment

Treatment draws on a range of therapeutic modalities tailored to each patient's unique needs and cultural context. These are complemented by culturally grounded and relational healing practices that honour Indigenous worldviews and promote balance in mental, physical, emotional and spiritual well-being. This strength-based, integrated approach supports both clinical and cultural pathways to healing, fostering resilience and long-term wellness for children, adolescents and their families.

## Who provides services

The IWSS Team comprises a program manager, cultural practice leads, Indigenous wellness specialists, and Elders and Knowledge Keepers who hold traditional knowledge of First Nation, Métis and Inuit traditions, ceremonies and wellness practices.

## How the service connects to other services and supports transitions

The IWSS Team provides cultural and spiritual care to First Nation, Métis and Inuit patients served in CASA programs and services. Consultation, resources and service navigation are accessible to all CASA staff, programs and teams to support the continuity of care of patients and their families.

## How we measure success

Success is measured by tracking service model outcomes that demonstrate increased cultural competency of CASA staff providing mental health care to Indigenous patients and their families, improved access to cultural and spiritual care for Indigenous patients served in CASA programs/services and increased mental health literacy of community service providers and school staff. These outcomes are monitored using a dedicated evaluation framework, which includes the use of screening tools, assessments, surveys and program level data collection to demonstrate effectiveness and responsiveness.

## Target Patient and Family Volume

	2026-27	2027-28	2028-29
<b>Patients</b>	25	75	135
<b>Families</b>	25	75	135

## Indigenous Wellness Group Programming

	2026-27	2027-28	2028-29
<b>Patients</b>	24	36	50
<b># of sessions</b>	24	36	50

## Cultural Competency: CASA Staff Education and Training

	2026-27	2027-28	2028-29
<b>Patients</b>	365	400	425
<b>Families</b>	3	8	12

## Consultation Services: CASA Staff

	2026-27	2027-28	2028-29
<b>Patients</b>	15	25	50
<b>Families</b>	15	25	50

## Professional Development and Consultation: Indigenous Community Service Providers/School Staff

	2026-27	2027-28	2028-29
<b>Service Providers</b>	20	35	50
<b>School Staff</b>	40	100	200
<b># of Consults</b>	7	15	30

### 2026-2027 Budget

#### Expenses

Salaries	846,318
Benefits	169,264
<b>Total Salaries and Employee Benefits</b>	<b>1,015,582</b>
Child & Family Supports	6,000
Program Materials & Supplies	37,000
Education, Conferences & Workshops	16,926
Team Building	850
Travel & Subsistence	16,000
Office Materials & Supplies	3,000
Other Services & Rentals	3,000
Professional Consulting / Services	11,000
<b>Total Program Expenses</b>	<b>93,776</b>
<b>Total Expenses</b>	<b>1,109,358</b>

#### Position Name

Professional Practice Lead, Cultural	1.00
Professional Practice Lead, Indigenous Services	1.00
Indigenous Wellness Practitioner	1.00
Indigenous Wellness Specialist	3.00
Senior Clinical Advisor	0.25
Manager, Indigenous Wellness Support Services	1.00
Program Support Lead	0.25
Practice Lead - Clinical	1.00

**Grand Total** **8.50**

# Integrated Concurrent Care

## Who we serve

Integrated Concurrent Care (ICC) is a clinical service that supports children and youth age seven to 18 either at risk of developing, or who meet criteria for, a substance use disorder or behavioural addiction and concurrently meet criteria for a mental health disorder. This often includes patients who present with a complex range of symptoms and possible trauma history.

## How we help

When a CASA patient is identified as having challenges with co-occurring substance or process use, Integrated Concurrent Care will be offered as an additional clinical resource for the patient, family/caregiver or both.

The following clinical programs in CASA are supported by a Concurrent Counsellor: Core, Trauma Program, Family Therapy Program, Adolescent Day Program and CASA House.

## What happens in the service

CASA House provides evidence-informed, trauma-informed and strengths-based support to help bolster existing services and target specific challenges with substance and/or process use. This involves four possible streams:

### Stream 1: Integrated Concurrent Care

At the triage level, patients who meet indicators for concurrent care needs and who are open and willing to engage in concurrent care may be assigned both a concurrent counsellor (CC) and a mental health therapist (MHT), or alternately the MHT can refer to the CC upon completion of their initial assessment. The MHT and CC engage with the patient and family collaboratively to ensure cohesive treatment planning, role clarity and quality care provision.

### Stream 2: Parallel or Sequential Concurrent Care

This stream may be explored if integrated concurrent care is prohibitively difficult to arrange or if the MHT is nearing completion of their work but concurrent concerns are starting to present. Other examples may include physician-only patients, or for waitlist management where addictions-related concerns have been identified as a significant area of concern and the patient may benefit from earlier intervention.

### Stream 3: Consultative Services

#### A. Clinician-to-Clinician Consultation

The Integrated Concurrent Care team can meet individually with clinicians to provide concurrent care consultation or attend case conferences to provide recommendations for concurrent concerns.

#### B. Capacity Building Workshops

The Concurrent Services team can deliver workshops or learning opportunities to teams for clinicians wanting to upskill their concurrent care knowledge.

#### C. Concurrent Care Parent Coaching Consultation

Limited session caregiver coaching sessions with a concurrent counsellor will be provided to caregivers who are motivated to support their child with concurrent care needs, but the child is yet to be ready or willing to connect with a concurrent counsellor. Depending on level of need, this may be provided through individual sessions or a group psychoeducational format.

### Stream 4: Concurrent Care Groups

#### A. Caregiver Coaching (Group Sessions)

Concurrent counsellors will lead caregiver psychoeducational groups to discuss caregiver strategies to manage complex concurrent presentations in the home. If patients are connected with a mental health therapist, the concurrent counsellor will arrange to provide updates and consultation via case conference, individual patient consultation meetings, or updates via the electronic medical system.

## B. Concurrent Care Groups for Youth

A variety of groups will be offered as required by the concurrent counsellor's program. Psychoeducational groups to provide knowledge about substance and process use, build skills to reduce use and more effectively manage the risks associated with substance use, develop healthy coping strategies and support recovery will be offered in all programs.

### Who provides care

The Concurrent Care team is made up of concurrent counsellors embedded within different CASA Mental Health programs, as well as a practice lead who is able to provide clinical leadership, guidance and consultation to counselors, MHTs and program staff.

### How the service connects to other programs/services

Because concurrent counsellors are embedded within the different programs, they are inherently integral parts of each program's functioning. They can be brought in for individual and group consults, and can be key parts of the care team for individual patients and families.

### How we measure success

Currently, ICC outcomes are often interconnected with individual program outcomes, such as improved clinical stability, family function and reintegration success.

As an individual service, ICC tracks outcomes such as:

- Unique patients served;
- New patients served;
- Number of communities served;
- Number of individual counselling/therapy/other activity sessions;
- Average number of counselling/other sessions per client;
- Number of group counselling/therapy/other sessions;
- Total number of counselling/therapy/other sessions ;
- Average wait time;
- Number of education presentations/training sessions delivered to clients; and
- Number of participants attending education presentations/training sessions.
- Target patient and family volume by program and location

	2026-27	2027-28	2028-29
<b>Patients</b>	325	325	325
<b>Families</b>	325	325	325



# Interprofessional Practice

## Who we serve

The Interprofessional Practice team supports clinical practices across the organization for health-care professionals within CASA providing concurrent counselling, nursing, rehabilitation and therapy services.

## How we help

The Interprofessional Practice team provides oversight of clinical practices across CASA for a variety of clinical disciplines, through development and implementation of standards of practice, evidence informed clinical practice and supervision frameworks, discipline specific and practice resources, recruitment and onboarding, accreditation and community of practices.

## What happens in the service

The team's mandate supports CASA's goal of delivering consistent, high-quality, patient and family-centred care to all children, adolescents and families accessing care at CASA Mental Health throughout Alberta. The program provides practice-specific leadership through ensuring the clinical practice delivered is rooted in evidence informed practices and aligns with CASA's organizational values. We provide oversight of standardization of clinical practices amongst multi-disciplinary teams, guide recruitment practices and ensure CASA as an organization meets and upholds accreditation standards. Additionally, we provide support for discipline-specific practices including guidance around regulatory college updates, registration, continuing competency and peer-to-peer community of practice support.

## Who provides care

Our team includes practice leads for the following disciplines: concurrent counsellors, nursing, rehabilitation services and therapy.

## How the service connects to other programs/services

Clinical practice needs are collaboratively identified with internal stakeholders to CASA. Development of standards of practice, policies and guiding resources are created with organization priorities in mind and include direct input from health-care professionals across all applicable CASA clinical programs. The team works alongside other CASA departments and programs to support with implementation and evaluation of CASA-wide clinical practices, such as the Strategic Clinical Council, Talent Acquisition, Professional Development and Education team, Change Management, and the Electronic Medical Record team.

## How we measure success

Program outcomes are evaluated based on the success of implementing and sustaining clinical practices across the organization, staff satisfaction with discipline-specific resources and support available, as well as receiving accreditation status with minimal required actions to be completed and maintained. Feedback data is regularly monitored, with a specific focus on collaboration, satisfaction, incorporation of CASA values and timely delivery of organizational initiatives.

## 2026-2027 Budget

### Expenses

Employment Contracts / Services	67,154
Salaries	609,885
Benefits	121,977

<b>Total Salaries and Employee Benefits</b>	<b>799,016</b>
Program Materials & Supplies	16,400
Education, Conferences & Workshops	12,198
Team Building	600
Travel & Subsistence	18,650
Office Materials & Supplies	500
Software & Subscription	14,600
Professional Consulting / Services	21,863
<b>Total Program Expenses</b>	<b>84,811</b>
<b>Total Expenses</b>	<b>883,827</b>

<b>Position Name</b>	<b>FTE</b>
Practice Lead, Nursing	2.00
Practice Lead, Rehab	1.00
Manager, Interprofessional Practice	1.00
Practice Lead, Concurrent Care	1.00
Practice Lead, Therapy	1.00
<b>Grand Total</b>	<b>6.00</b>



# Medical Affairs

## Who we serve

Medical Affairs includes the Medical Director and Medical Affairs Coordinator, and primarily supports CASA physicians. The department also plays a key role in liaising with CASA operations including Occupational Health and Patient Safety, IDEA, People and Culture student placement, Quality Improvement and Business Intelligence and Evaluation. By supporting physicians and CASA as a whole, we better serve patients and families and empower them to thrive.

## How we help

The Medical Affairs Department at CASA plays a supportive and guiding role across the organization, offering clinical, scientific and administrative expertise to help ensure programs, services and communications maintain high standards of medical accuracy, safety and ethical practice. As a central source of medical guidance, the department helps CASA deliver care that is compassionate, evidence-informed, effective and responsive to the needs of the community.

## What happens in the service

The Medical Affairs department oversees key processes that ensure CASA's medical staff are qualified, supported and able to deliver safe, effective care. This includes managing hiring and credentialing, maintaining professional memberships and coordinating ongoing training so physicians continue to grow clinically and in their capacity as leaders.

Medical Affairs also plays a central role in ensuring that medical staff policies and procedures align with best practices, professional standards and regulatory expectations. The department emphasizes supportive education and advocacy to uphold safety and consistent quality care across the organization. In collaboration with medical experts and careholders, our aim is to foster a sustained commitment to informed and community-centered care along with outcomes-based accountability at CASA.

Medical Affairs promotes strong relationships between physicians, staff and the patients and families we serve. It supports the physician experience, and in turn the patient experience, for better patient care and satisfaction. We use the physician perspective to advocate and advance medical system needs.

## Who delivers the service

Medical Director and Medical Affairs Coordinator.

## How we connect across CASA

The Medical Director works closely with the Medical Affairs Coordinator, who serves as a key liaison between clinical teams and operational leaders across the organization. The Medical Director meets regularly with medical leads, the full psychiatric medical staff, and physicians on an individual basis. We coordinate relevant communication to the physicians and foster deliberate engagement in organizational updates, initiatives and strategic planning. Through these connections, the department helps align medical perspectives with CASA's broader operational goals.

## How we measure success

Although Medical Affairs is newly established, its vision is to build a strong, well-developed department that meaningfully supports medical staff and contributes to CASA's overall success. Our primary goals include fostering physician engagement, enabling clinicians to work to the top of their scope and standards, and supporting their effective integration within teams. We use feedback and audit results to help ensure our metrics are being achieved.

### Key metrics include:

- Successful recruitment and onboarding required physician positions;

- Ensuring contracts and privileges are maintained in a timely way;
- Ensuring regular performance reviews are completed;
- Hosting professional development days to support physicians in practicing at a standard of excellence;
- Supporting physician participation in organization educational events and quality improvement initiatives;
- Supporting compliance with professional standards; and
- Promoting operational needs of the organization physician awareness.



# Preschool Day Program

## Who we serve

The Preschool Day Program (PDP; pre-kindergarten and kindergarten) is a tertiary-level, interdisciplinary diagnostic and therapeutic educational resource for children age four and five who are experiencing severe challenges regulating their emotions and behaviour. These challenges have impacted their ability to participate meaningfully in the home and community programs, and associated difficulties with development, executive functioning and learning may be evident.

## How we help

The program provides intensive family-centred diagnostic review and therapeutic education, developmental intervention and academic instruction in a specialized early childhood setting. Children attend two full days per week for the 10-month school year, either Tuesday and Thursday, or Wednesday and Friday. There is a maximum class size of nine children.

## What happens in the program

PDP follows an evidence-informed, trauma-informed and strength-based framework designed to enhance healthy social-emotional, cognitive and physical development and strengthen the family's ability to support their child's development and learning by promoting parent confidence and competence.

An additional area of focus includes promoting school readiness to facilitate an effective transition to community schools and services. The family and the interdisciplinary care team collaborate on individualized goals.

Therapeutic modalities include:

- Diagnostic and medication review;
- Occupational therapy group;
- Speech-language group;
- Psychoeducational parent group;
- Individual family-orientated therapy;
- Parent-Child Interaction Therapy (PCIT);
- PATHS: Promoting Alternative Thinking Strategies (a social-emotional competency program); and
- Handwriting Without Tears.

Parent-Child Interaction Therapy (PCIT) is the core evidence-based treatment at PDP for children with challenging disruptive behaviours, integrating attachment and social learning theories. It focuses on coaching parents or caregivers to recognize and reward positive behaviours, strengthening parent-child interactions and reducing coercive cycles. Repeated practice and immediate feedback help parents build competence and confidence in their parenting skills.

## Who provides care

The PDP team includes teachers, educational assistants, mental health therapists, psychiatrists, nurses, therapy support assistants, assessment psychologists, occupational and speech therapists and assistants, and therapy support navigators. The interprofessional team meets weekly to discuss patients' assessments, goals and progress in treatment.

## How the program connects to other services and supports transitions

PDP functions within a broader continuum of care, coordinating with community-based services to ensure smooth transitions. During a patient's treatment in the program, the multidisciplinary team may determine, in conjunction with the family, that a different level of service is required.

Other CASA programs such as Core, Family or Trauma programs may be accessed if specialized care in these areas is required. Step-down care from PDP may be appropriate when a patient and their family has completed their course of care and less intensive supports are required.

Transition support staff collaborate with the multidisciplinary team to provide proactive, post-treatment coordination before and after discharge. Families are engaged to co-create a transition plan that addresses community, school and health-care needs. Non-urgent, follow-up transition support is provided for a defined period after discharge, typically for another full semester. Community mental health providers, along with community schools and parents or caregivers, are invited to a comprehensive transition meeting at discharge that outlines effective interventions, assessment results and strategies suggested for continuation within the community school and home settings.

Non-urgent, follow-up transition support is provided for a defined period after discharge, typically for another full semester. This support can include community visits, school observations and meetings, and connection to mental health-care and services within the community.

## How we measure success

Program outcomes are demonstrated by improved classroom functioning, progress towards developmental milestones and parenting confidence. The Preschool Day Program tracks outcomes such as:

- Diagnostic clarity and symptom reduction;
- Aggression and social functioning;
- Communication and fine and gross motor skills;
- Parenting stress;
- Caregiver satisfaction; and
- Warm hand-offs to community-based service providers.

## Target patient and family volume by location

### Edmonton

	2026-27	2027-28	2028-29
<b>Patients</b>	18	18	18
<b>Families</b>	18	18	18

### 2026-2027 Budget

#### Expenses

Employment Contracts / Services	199,109
Salaries	689,102
Benefits	137,820
<b>Total Salaries and Employee Benefits</b>	<b>1,026,031</b>
Recreation	1,200
Child & Family Supports	19,460
Program Materials & Supplies	28,000
Education, Conferences & Workshops	13,782
Team Building	790
Travel & Subsistence	1,000
Clinical Consultation	17,280
Office Materials & Supplies	2,000
Accounting / Audit Fees	17,425
Professional Consulting / Services	15,000
<b>Total Program Expenses</b>	<b>115,937</b>
<b>Total Expenses</b>	<b>1,141,968</b>

<b>Position Name</b>	<b>FTE</b>
Assessment Psychologist	0.35
Mental Health Therapist	2.00
Occupational Therapist	0.50
Occupational Therapy Assistant	0.50
Program Manager, Day Programs	0.33
Speech Language Assistant	0.75
Speech Language Pathologist	0.50
Therapy Support Assistant	1.00
Therapy Support Navigator	0.66
Mental Health Nurse	0.50
Program Supervisor	0.66
<b>Grand Total</b>	<b>7.75</b>



# Professional Development and Education

## Who we serve

The Clinical Professional Development and Education team provides consultation, coaching, education and mentoring to mental health professionals within CASA and select partner organizations in rural Alberta.

## How we help

Our program fosters clinical skill development in mental health professionals, utilizing a child and family-centered approach to care. Program offerings are tailored to the needs of clinicians and support professional development across varying levels of experience and expertise.

## What happens in the service

The team's mandate supports CASA's goal of becoming an internationally-recognized learning and teaching organization by sharing knowledge and building capacity. The program provides formal learning events, coaching, consultation and mentoring to CASA staff across the province and to external mental health providers in Recovery Alberta's north and central east zones. We also provide training related to CASA's clinical procedures and standardized tools such as HONOSCA, CALOCUS, Therapeutic Crisis Intervention and safety pods.

## Examples of program offerings include:

### **Orientation to Child and Adolescent Mental Health**

The team offers orientation to practice support for novice clinicians through a series of individual or group sessions related to foundational topics in children's mental health. This service is targeted towards new children's mental health therapists.

### **Clinical Consultation**

The team offers consultation related to clinical service provision to patients (infant to early adulthood) and their families. Consultation involves discussing specific clinical cases and integrating theoretical knowledge and tangible strategies to support therapeutic services. Group consultation is available and promotes networking and sharing of resources and ideas as well as capitalizing on the wisdom of others in learning from one another.

### **Coaching**

The team provides coaching to children's mental health therapists through self-referral or referral by their supervisor. Coaching provides an opportunity for professional development related to a specific skill set or intervention of clinical interest.

### **Education and Training**

The team facilitates educational training events on a variety of theoretical, clinical and professional practice topics relevant to children's mental health. Each training event is customized to meet the needs of the requesting party and attendees. Training events are offered in-person or virtually. They can vary in length from one hour to several days depending on the topic, content and needs of the requesting party. The consultants utilize the following principles of adult education to create a safe and inviting environment that maximizes the potential for learning:

#### **1. Communities of Practice**

The intent of the communities of practice venue is to engage therapists in social learning as a way of linking learning and theory from an educational training or focused topic area to practice. It also can increase professional growth and identity through therapist self-confidence, self-mastery of theoretical aspects and development of methods, skills and practice knowledge.

#### **2. Therapeutic Crisis Intervention**

The Therapeutic Crisis Intervention (TCI) training program presents a crisis prevention and intervention model designed to teach staff how to help youth learn constructive ways to handle crises. The ability of the

entire organization to respond effectively to young people in crises is critical in establishing not only a safe environment but also one that promotes growth and development. The skills, knowledge, and professional judgment of staff in responding to crises are critical factors in helping young people learn constructive and adaptive ways to deal with frustration, failure, anger, rejection, hurt and depression.

### 3. Safety Pod Training and Consultation

A safety pod is a specialized piece of equipment which, on its own, can primarily be a comforting and therapeutic piece of furniture that meets the safety standards required for use in high-risk environments. Safety pods can also be used as a restrictive intervention through the use of a specific physical restraint onto the safety pod by certified staff.

## Who provides care

Our team includes mental health consultants, clinical educators, Therapeutic Crisis Intervention educators and educational assistants.

## How the service connects to other programs/services

Training needs are collaboratively identified with service partners both internal and external to CASA. Program offerings are created with organizational priorities in mind and include direct input from programs accessing these services. All participants also have an opportunity to provide anonymous feedback.

## How we measure success

Program outcomes are evaluated based on the number of program offerings (i.e., trainings, consultations, coaching sessions and mentoring meetings), participants and communities reached. Feedback data is regularly monitored, with a specific focus on relevance, applicability and overall satisfaction ratings from participants.

## Target patient and family volume by program and location

Projected number of education presentations/training sessions delivered:

	2026-27	2027-28	2028-29
Projected number of education presentations/training sessions delivered	50	50	50
Projected number of participants	800	800	800
Projected number communities reached	20	20	20

## 2026-2027 Budget

### Expenses

Salaries	1,068,406
Benefits	213,681
<b>Total Salaries and Employee Benefits</b>	<b>1,282,087</b>
Program Materials & Supplies	10,000
Education, Conferences & Workshops	21,368
Team Building	1,100
Travel & Subsistence	45,000

Office Materials & Supplies	2,000
Software & Subscription	8,500
Professional Consulting / Services	16,000
<b>Total Program Expenses</b>	<b>103,968</b>
<b>Total Expenses</b>	<b>1,386,055</b>

<b>Position Name</b>	<b>FTE</b>
Education Assistant	2.00
Mental Health Consultant	4.80
Clinical Educator	1.80
Manager, Clinical Professional Development and Education	1.00
TCI Educator	1.00
<b>Grand Total</b>	<b>10.60</b>



# Psychological Assessment and Consultation

## Who we serve

The Psychological Assessment and Consultation (PAC) team provides services to multiple programs across CASA including Core, Trauma Clinic, Family Therapy, Psychiatry and Medical Clinics, Preschool Day Program, Children's Day Program, Adolescent Day Program and CASA House.

## How we help

PAC strives to provide psychological assessment and consultation services to help patients, caregivers and care teams to better understand a child's cognitive, academic and emotional/behavioural/social strengths and challenges to aid in diagnostic clarity and direction for treatment planning and goals. PAC provides recommendations for further intervention, supports and accommodations to caregivers, educators and CASA care teams to help support the child's overall development, learning, daily living and mental health. Ultimately, PAC aims to reduce barriers to specialized assessment services that children and youth require, enhance the understanding of a child's strengths and areas of need, help families advocate for their children's needs at school and in the community, and share information with community providers. PAC works with CASA families and care teams on a referral basis. Average length of service is three months. All services happen onsite at all CASA locations.

## What happens in the service

**Consultation:** PAC offers consultation services to CASA service providers and caregivers. Consultations offered to CASA providers include, but are not limited to, guidance for assessment services, differential diagnosis, diagnostic clarity and type of treatment based on cognitive/academic functioning. Consultation offered to caregivers includes support and guidance for educational programming and supports and psychoeducation of neurodevelopmental disorders.

**Assessment:** PAC offers specialized assessment services that cater to specific concerns and/or questions of care teams, individual therapists and individual care providers. Assessments include direct or indirect evaluation of cognitive functioning, academic achievement, executive functioning, memory, personality, behavioural/emotional functioning, social communication and adaptive functioning. Assessment results and recommendations support treatment planning, school programming and enhancing understanding of a child's strengths and needs.

**Classroom Observation:** PAC offers observations without intervention within the classroom and daycare natural environment to document a child's behavioural functioning. The collected information, combined with the child's history, is amalgamated into a written report and provided to service providers to assist in treatment planning within CASA programs and to facilitate the implementation of intervention techniques in partnership with parents/guardians, schools and daycares.

**Report Translation:** PAC offers interpretation of previous psychological assessments to CASA service providers and caregivers to enhance their understanding of assessment results and recommendations, and to facilitate implementation of information into treatment, home and school environments. As well, report translation may lead to further recommendations for assessment and/or observation.

## Who provides care

The PAC team includes registered psychologists who specialize in psychological assessment and consultation, a classroom behaviour consultant and a psychological assistant. PAC psychologists collaborate through regular internal consultation. A classroom behaviour consultant and psychological assistant support PAC psychologists during the assessment process.

## How the service connects to other programs/services

**Outpatient Programs:** Psychologists provide assessment and consultation services upon referral from the patient's treatment team. Assessment results and recommendations are discussed at case conferences with

a patient's treatment team and/or with individual CASA providers. Recommendations from the assessment are incorporated into a patient's treatment plan. Classroom behaviour consultant observation reports are shared with the treatment team, and information is used to inform a patient's treatment plan.

**Day Programs and CASA House:** Psychologists provide assessment and consultation services upon referral from the patient's treatment team. Assessment results and recommendations support treatment planning within CASA and transition back into programming in the community.

### How we measure success

**Patient and family satisfaction:** quality of assessment services and comprehension and functionality of results and recommendations are measured.

**Number of children/youth served:** Number children/youth and number of families who received services (consultation, observation and assessment).

**Number of assessments completed:** Number of psychological assessments completed.

### Target patient and family volume by program and location

Psychological Assessment Services only:

#### Core and Psychiatry and Medical Clinics

	2026-27	2027-28	2028-29
<b>Patients</b>	80	90	100
<b>Families</b>	80	90	100

#### Trauma and Family

	2026-27	2027-28	2028-29
<b>Patients</b>	40	40	40
<b>Families</b>	40	40	40

#### Day Programs

	2026-27	2027-28	2028-29
<b>Patients</b>	25	25	25
<b>Families</b>	25	25	25

#### CASA House

	2026-27	2027-28	2028-29
<b>Patients</b>	50	50	50
<b>Families</b>	50	50	50

### 2026-2027 Budget

#### Expenses

Salaries	791,118
Benefits	158,224
<b>Total Salaries and Employee Benefits</b>	<b>949,341</b>
Program Materials & Supplies	12,000
Education, Conferences & Workshops	15,822
Team Building	800

Travel & Subsistence	7,000
Office Materials & Supplies	1,000
IT Materials & Supplies	1,000
<b>Total Program Expenses</b>	<b>37,622</b>
<b>Total Expenses</b>	<b>986,963</b>

<b>Position Name</b>	<b>FTE</b>
Assessment Psychologist	4.43
Psychological Assistant	1.00
Classroom Behaviour Consultant	1.00
Manager, Assessment and Consultation	1.00
<b>Grand Total</b>	<b>7.43</b>



# Psychiatry and Medical Clinics

## Who we serve

The Psychiatry and Medical Clinics program serves children and youth (four to 18 years) who primarily require physician-led care for complex psychiatric and medical needs. These patients typically have CALOCUS levels 3 to 5, necessitating specialized treatment and support. The program focuses on providing comprehensive psychiatric care while connecting families to essential community resources. Patients currently include those under the care of CASA psychiatrists, with plans to expand to new external referrals as the program grows in scope.

## How we help

The program provides collaborative, interprofessional, wrap-around services for children, youth and their families. Care includes:

- Comprehensive assessment and diagnosis;
- Medication management;
- Symptom screening and stabilization;
- Therapeutic skill building;
- Caregiver support and psychoeducation; and
- Case management, including collaboration with schools and community partners.

Individualized treatment plans are developed to address psychiatric, medical, developmental and psychosocial needs. Length of stay varies—from months to several years—and can continue until transition to adulthood, based on patient complexity and family support needs.

## What happens in the program

The program emphasizes coordinated pathways within the mental health system to ensure patients and families receive the most appropriate internal and community supports.

The clinical approach includes:

- Diagnostic clarification and symptom stabilization;
- Medication management;
- Building resilience through evidence-informed interventions;
- Strengthening coping, communication and relational skills;
- Case management and coordinated care;
- Collaboration with community providers and smooth transition to community supports;
- Timely access to psychiatric and mental health services; and
- Regular appointments and follow-up with psychiatrists, nurses, therapy support navigators and other clinicians as needed.

## Who provides care

Care is delivered by an interprofessional team that includes:

- psychiatrists;
- mental health nurses;
- therapy support navigators (TSNs);
- physician support specialists (PSSs);
- program managers;
- pharmacists; and
- specialty care providers as needed, including an occupational therapist, speech and language therapist, nutritionist, sleep specialist or neurodevelopmental physician.

## How the program connects to other services and supports transitions

The Psychiatry and Medical Clinics program supports seamless transitions within CASA and across community systems to ensure continuity of care. The program collaborates with other CASA services and provides warm handoffs.

During treatment, the interprofessional team may facilitate step-up services when a higher level of care is needed, connecting patients to programs such as Core, day programs and Family or Trauma Services. As patients stabilize, step-down planning supports transition back to primary care and community-based services. Warm handoffs are provided, including relevant medical and mental health information, to community pediatricians, general practitioners, primary care networks, schools, mental health agencies and social supports to ensure ongoing care.

## How we measure success

Program success is evaluated using clinical, operational, and experiential indicators:

- **Patient and family satisfaction:** ongoing surveys, interviews and check-ins;
- **Staff satisfaction and team functioning:** assessing collaboration, workload and program growth;
- **Access to services:** monitoring wait times, response times and availability of urgent or high-priority appointments;
- **Program growth and adaptability:** capacity to scale staffing, integrate specialty providers and establish external referral pathways;
- **Long-term clinical outcomes:** symptom improvement, medication adherence, functional stability and post-discharge progress;
- **Program review and quality improvement:** ensuring alignment with best practices; and
- **Data tracking:** admissions, discharges and length of stay to understand utilization and effectiveness.

## Target patient and family volume

In 2025, CASA transitioned more than 700 existing physician-led cases into the Psychiatry and Medical Clinics program. The program served 851 unique patients and provided care to 380 family members, with 529 total appointments.

The target for the upcoming year is to serve 900 unique patients and 400 family members, with a total of 550 appointments. External referral pathways are planned for launch in 2026 to expand access for children and youth across the community.

	2026-27	2027-28
<b>Patients</b>	900	1,000
<b>Family Members</b>	750	800

## 2026-2027 Budget

### Expenses

Salaries	947,714
Benefits	189,543
<b>Total Salaries and Employee Benefits</b>	<b>1,137,257</b>
Child & Family Supports	2,000
Program Materials & Supplies	3,500
Education, Conferences & Workshops	18,954
Team Building	1,100

Travel & Subsistence	3,000
Clinical Consultation	35,000
Clinical Contracts / Services	15,100
Office Materials & Supplies	4,000
<b>Total Program Expenses</b>	<b>82,654</b>
<b>Total Expenses</b>	<b>1,219,911</b>

<b>Position Name</b>	<b>FTE</b>
Mental Health Nurse	6.40
Therapy Support Navigator	2.00
Program Manager	1.00
Pharmacist	0.60
<b>Grand Total</b>	<b>10.00</b>



# Trauma Program

## Who we serve

The Trauma Program is a voluntary, CALOCUS Levels 3 to 4, outpatient program providing specialized, trauma- and attachment- focused mental health services for children and youth aged five to 17 who have experienced complex developmental trauma and, as a result, are experiencing significant challenges with daily functioning. The children require treatment that is a step up from primary care mental health.

The diagnoses of complex developmental trauma (e.g. Complex PTSD, Reactive Attachment Disorder, Disinhibited Social Engagement Disorder) may be given or queried for children/youth in the program. They also may experience a myriad of other needs, including significant mental health challenges, family dysfunction, socio-economical challenges and intergenerational trauma.

## How we help

The treatment goals of the Trauma Program may include:

- assessment, conceptualization and, when needed, diagnostic clarification;
- trauma and attachment-injury symptom stabilization and functional improvement through a focus on stabilization, regulation and trauma processing;
- increased caregiver skill and capacity; and
- connection/transition to formal and natural supports in the community.

The length of care is unique to each child. This can include individual/dyadic sessions, group therapy involvement and/or community outreach. The number and type of sessions and length of involvement are dependent on the child, youth and caregivers' therapeutic needs, level of stabilization and therapeutic progress.

Acknowledging that the healing of developmental trauma is a non-linear, lifelong journey, the Trauma Program encourages youth and families to return to lower-intensity community-based supports after care and return for further care based on the child/youth's developmental progress.

## What happens in the program

The Trauma Program delivers care in four streams:

### Stream 1: Outpatient Trauma Clinic

The outpatient clinic works with children, youth and caregivers through individual and dyadic therapy. This clinic may be utilized as a stand-alone, full course of trauma treatment, or for the initial stabilization work in preparation for enrollment in Stream 2, the Trauma and Attachment Group.

Throughout the course of therapy, therapists complete an assessment of the child/youth and caregiver's trauma and attachment history, the child's functioning and presenting issues, and the family's functioning. In collaboration with the family, trauma therapy goals are established and a trauma treatment plan is created.

Due to the dyadic (caregiver-inclusive) nature of the therapy, children/youth accepted into the program must be in a stable and permanent home for the past six months to a year, preferably under the care of caregivers who were/are not part of the child's trauma story.

Modalities used in the Trauma Clinic may include but not limited to:

- Somatic and sensory-motor approaches;
- Play-based approaches;
- Sand tray therapy;
- Theraplay and/or attachment-focused play;
- Bilateral stimulation processing approaches (e.g., ART and EMDR);
- Dyadic-focused therapy;
- Narrative approaches;

- CBT/DBT informed approaches;
- Psychoeducation; and
- Caregiver coaching (to address caregiver blocks and to generalize therapy skills into daily living).

## Stream 2: Trauma and Attachment Groups (TAG)

The Trauma and Attachment Group (TAG) is a highly-structured treatment program for children and their caregivers who have experienced trauma and severely disrupted attachment. This is a full-year commitment to weekly therapy with winter and summer breaks, with varying start dates. The TAG program is designed to promote attachment behaviours in children/youth who live with attachment disorders. Traumatic events most evident in this program are neglect and/or physical, mental or sexual abuse.

Entry into the TAG Program is contingent on the successful establishment of group readiness, stability and safety through Stream 1, Outpatient Trauma Clinic.

Modalities used in the Trauma and Attachment Group may include, but are not limited to:

- Somatic and sensory motor approaches;
- Sand tray therapy;
- Theraplay and/or attachment-focused play;
- Narrative approaches;
- CBT/DBT informed approaches; and
- Psychoeducation (to address caregiver blocks).

A Trauma and Attachment Parenting Support Group is also offered under the TAG umbrella in tandem with Stream 1 Outpatient Trauma Clinic services. This is an eight-week caregiver-only group that focuses on caregiver psychoeducation on common trauma and attachment-injury symptoms, advanced attachment-focused parenting skills, and strategies to dismantle caregiver blocks when parenting children with exceptional needs.

## Stream 3: Community Outreach

The community outreach stream provides tailored mental health support to youth who have experienced trauma by engaging with them in the context of their present needs and level of readiness. Outreach therapists offer mental health assessment, stabilization and trauma-informed intervention in collaboratively supported community settings. This flexible support adapts to each youth's level of regulation and therapeutic need. The outreach stream works collaboratively with community partners to guide youth toward sustainable supports and mental health treatment.

## Stream 4: Consultative Services

The Trauma Program's consultative stream provides one-time or limited session consultations with therapists from other mental health programs interested in building further trauma therapy components into the work with their clients.

## Who provides care

The Trauma Therapy Program comprises a core interprofessional team including child psychiatrists\*, adult psychiatrists†, mental health therapists (social workers, psychologists, occupational therapists), concurrent counsellors‡, mental health nurses and/or therapy support navigators.

Together, these professionals employ a holistic, multi-faceted blend of therapeutic modalities to facilitate the healing of trauma and attachment wounds and support the growth and resiliencies of families.

*\* Offered in programs with child psychiatry (currently only in the Edmonton program)*

*† Offered in programs with adult psychiatry (currently only in the Edmonton program)*

*‡ Offered in programs with concurrent counsellors (currently only in the Edmonton program)*

## How the program connects to other services and supports transitions

During a patient's treatment in the program, the interprofessional team may determine, in conjunction with the family, when a different level of service may be required.

**Step-up services** may be needed temporarily to allow for an enhanced level of stabilization and safety. Accessing crisis services or hospital treatment will be discussed with clients and caregivers as needed.

**Step-down services** may be appropriate when care is completed or if the therapeutic readiness for trauma processing has decreased, and primary care support is required instead of trauma processing. Program staff may then work to connect the patient and family to community programs to build their natural and formal support networks and make a referral to primary care mental health.

Lastly, a therapeutic break may be chosen, in collaboration with the family, with the goal of enhancing motivation and readiness to engage in specialized trauma treatment. Therapy support navigators in the program will ensure families have access to either formal or natural supports in their community before the onset of a therapeutic break.

## How we measure success

Trauma Program outcomes demonstrate improved clinical stability in relation to the individual, dyadic relationship and family system. The Trauma Program tracks outcomes such as:

- Trauma symptom reduction;
- Improvement in dyadic relationships and/or family relationships; and
- Increase in parental reflective functioning and decrease in parental stress levels.

## Target patient and family volume by location

### Edmonton

	2026-27	2027-28	2028-29
<b>Patients</b>	350	350	350
<b>Family Members</b>	450	450	450

### Calgary

	2026-27	2027-28	2028-29
<b>Patients</b>	100	125	125
<b>Family Members</b>	125	175	175

## Total 2026-2027 Budget

### Expenses

Salaries	1,756,883
Benefits	351,377

### **Total Salaries and Employee Benefits 2,108,259**

Child & Family Supports	9,000
Program Materials & Supplies	18,400
Education, Conferences & Workshops	42,638
Team Building	2,000
Travel & Subsistence	27,000
Clinical Consultation	60,742
Clinical Contracts / Services	2,400
Office Materials & Supplies	8,000
Software & Subscription	1,000
Other Services & Rentals	1,000

### **Total Program Expenses 172,180**

### **Total Expenses 2,280,439**

<b>Position Name</b>	<b>FTE</b>
Concurrent Counsellor	0.50
Mental Health Nurse	1.00
Mental Health Therapist	10.40
Program Supervisor	2.00
Therapy Support Navigator	3.00
Program Manager	1.50
<b>Grand Total</b>	<b>18.40</b>

## Edmonton

### 2026-2027 Budget

#### Expenses

Salaries	945,843
Benefits	189,169
<b>Total Salaries and Employee Benefits</b>	<b>1,135,012</b>
Child & Family Supports	3,000
Program Materials & Supplies	7,400
Education, Conferences & Workshops	18,917
Team Building	1,100
Travel & Subsistence	2,000
Clinical Consultation	43,462
Clinical Contracts / Services	2,400
Office Materials & Supplies	4,000
Other Services & Rentals	1,000
<b>Total Program Expenses</b>	<b>83,279</b>
<b>Total Expenses</b>	<b>1,218,291</b>

<b>Position Name</b>	<b>FTE</b>
Mental Health Therapist	6.40
Therapy Support Navigator	2.00
Program Supervisor	1.00
Program Manager	0.50
Concurrent Counsellor	0.50
<b>Grand Total</b>	<b>10.40</b>

## Calgary

### 2026-2027 Budget

#### Expenses

Salaries	811,039
Benefits	162,208
<b>Total Salaries and Employee Benefits</b>	<b>973,247</b>
Child & Family Supports	6,000
Program Materials & Supplies	11,000
Education, Conferences & Workshops	23,721
Team Building	900
Travel & Subsistence	25,000
Clinical Consultation	17,280
Office Materials & Supplies	4,000
Software & Subscription	1,000
<b>Total Program Expenses</b>	<b>88,901</b>
<b>Total Expenses</b>	<b>1,062,148</b>

#### Position Name

#### FTE

Mental Health Nurse	1.00
Mental Health Therapist	4.00
Program Supervisor	1.00
Therapy Support Navigator	1.00
Program Manager	1.00
<b>Grand Total</b>	<b>8.00</b>



# Triage, Navigation and Transition

## Who we serve

Triage, Navigation and Transition (TNT) supports children, youth and families in the Edmonton area who are either entering CASA, moving between CASA programs, or preparing to move from CASA and back into community care.

We work with families who may be seeking mental health support, unsure of where to go, or need help understanding what services are available. We serve patients and families who need help navigating the mental health system, and we work to make sure patients receive the right services at the right time while also improving the experience for service providers and community partners who rely on accurate, coordinated information.

## How we help

Triage, Navigation and Transition is the formal entry point for many children, youth and families beginning and ending their mental health journey at CASA. Its purpose is to provide a clear, consistent and coordinated pathway through care by guiding families through the intake process, answering questions, gathering essential information and connecting them to the service that best meets their needs.

Triage ensures that families are directed to the most appropriate program at the right time, creating a smooth and integrated start to their mental health care. The Transition team supports families as they complete their time at CASA by developing transition care plans, coordinating with internal teams and fostering partnerships with community providers to ensure a warm handoff and continuity of care. This helps reduce confusion, prevents gaps in services and supports families in feeling prepared for next steps.

Transition Services are provided through phone, virtual and in-person appointments as needed. Families are typically in triage for an average of one to four weeks, while the transition program offers short-term supports focused on active goal engagement toward a successful move into community services. Triage, Navigation and Transition is currently working with other programs within CASA Mental Health to build pathways within CASA to improve navigation between programs as well.

## What happens in the service

Triage, Navigation and Transition uses a strengths-based and family-centred approach to understand patients' unique needs, build on existing skills and supports, and create individualized care plans that encourage hope and clarity as families move through their mental health journey.

Triage, Navigation and Transition team is offered at all CASA clinical sites in the Edmonton area, helping make the intake process accessible and convenient for families entering CASA programs or leaving CASA, thereby reducing barriers and supporting a timely start to care. As CASA Mental Health expands, the TNT model will be explored as a potential blueprint for similar services in other areas.

## Triage Services

In the triage stage, the team's goal is to understand patients' unique needs and connect them to the right services at the right time. This process helps families begin care quickly, prevents unnecessary delays and ensures they are matched with programs that are the best fit.

## Navigation Services

Historically, Triage, Navigation and Transition has formally helped with entry into CASA Mental Health programs, and transition back to the community. We have also provided step-up and step-down services to help support patients and families moving from one program to another within CASA. Our team is currently working on a more formal plan to improve navigation for patients moving internally between CASA Mental Health programs in general.

## Transition Services

Transition services help families prepare to move from CASA programs to community supports. The team works closely with families to understand their needs, provide coaching for parents and patients, and identify natural supports such as family members, schools or community groups. Staff help with referrals and applications to outside programs, making sure families know what to do and have the resources they need. Services can take place at CASA or in the community, depending on what works best for the patient and family. Transition support is short-term and goal-focused, with active engagement to help families achieve their goals and move confidently into community services.

### **Therapeutic support using evidence-informed approaches, including:**

- Psychopharmacology teaching;
- Solution-focused therapy;
- Motivational interviewing;
- CBT and DBT strategies;
- Harm reduction and health promotion;
- Safety planning;
- Strengths-based and resiliency approaches;
- Emotion-focused strategies;
- Parent coaching;
- Mental status exams; and
- Screening tools (e.g., ASQ, SDQ).

## Who provides care

Triage, Navigation and Transition s delivered by a specialized multidisciplinary team including a psychiatrist, therapy support navigators, mental health therapists and nurses who all work together to provide coordinated, evidence-informed care. The team meets weekly to review assessments and individualized care plans, aligns therapeutic interventions with psychiatric recommendations, and coordinates family coaching, health education and safety planning to support continuity of care. Regular communication among team members and with families ensures pathway/guidance is clear, consistent and responsive to each family's needs.

## How the service connects to other services

Triage, Navigation and Transition serves as a beginning and end point in the continuum of care, helping families move smoothly between programs based on their needs.

**Step-Up Services:** In Triage, children and youth are assessed promptly and connected to higher-level services such as targeted therapy, psychiatric services or more frequent clinical follow-up. Transition services also support step-up connections by coordinating with internal CASA programs and external providers to ensure children access the specialized support they need. This process helps prevent delays in care and ensures children receive the right level of support at the right time.

**Step-Down Services:** Triage can navigate families to services such as outpatient therapy, community programs or short-term transition supports, while Transition services can also navigate and facilitate these step-down connections through ongoing planning, coaching and coordination. Both Triage and Transition work together to ensure that step-down transitions are smooth, care remains appropriate and families are supported as they navigate and integrate into the community.

**Transition Planning and Collaboration:** Transition planning begins early, with the team working closely with families to identify goals, strengths and needs. The plan can include coordination with internal CASA programs, as well as natural supports like family, schools and community organizations. Staff also collaborate directly with external providers to ensure a warm handoff, where information and resources are clearly communicated to support navigation and prevent gaps in care.

## How we measure success

Triage, Navigation and Transition measures success by considering both the outcomes for families and youth as well as how effectively our services are delivered.

To track these outcomes, we monitor factors such as how quickly families access services, the completion of individualized care and transition plans, and follow-up engagement with community supports after discharge. This year, we introduced surveys to gather direct feedback from both families and service providers. These surveys help us understand whether families feel prepared, supported and confident in their care, and whether providers find the transition process smooth and effective.

By combining survey results with clinical and service data, the team can identify trends, spot areas for improvement and make informed adjustments to the program. This ongoing evaluation ensures that the Triage and Transition program continues to meet its goals, enhance the experience for families and support positive outcomes for children and youth.

## Target patient and family volume by program and location

### Triage

	2026-27	2027-28	2028-29
<b>Patients</b>	1,200	1,500	1,800

### Transitions

	2026-27	2027-28	2028-29
<b>Patients</b>	150	200	300

## 2026-2027 Budget

### Expenses

Salaries	1,289,551
Benefits	257,910
<b>Total Salaries and Employee Benefits</b>	<b>1,547,462</b>
Child & Family Supports	1,000
Program Materials & Supplies	1,500
Education, Conferences & Workshops	25,791
Team Building	1,500
Travel & Subsistence	4,000
Clinical Consultation	20,000
Office Materials & Supplies	3,000
Software & Subscription	6,500
<b>Total Program Expenses</b>	<b>63,291</b>
<b>Total Expenses</b>	<b>1,610,753</b>

### Position Name

Mental Health Nurse	2.00
Mental Health Therapist	5.00
Therapy Support Navigator	7.00
Manager, Triage, Navigation and Transitions	1.00
<b>Grand Total</b>	<b>15.00</b>



# Business Departments

# Office of the Chief Executive Officer

## 2026-2027 Budget

### Expenses

Salaries	523,607
Benefits	104,721
<b>Total Salaries and Employee Benefits</b>	<b>628,328</b>
Program Materials & Supplies	6,000
Education, Conferences & Workshops	35,959
Team Building	300
Travel & Subsistence	10,000
Board Expenses	40,000
AGM Expenses	2,500
Legal Fees	30,000
Other Services & Rentals	17,500
Professional Consulting / Services	120,000
<b>Total Program Expenses</b>	<b>262,259</b>
<b>Total Expenses</b>	<b>890,587</b>

### Position Name

### FTE

Chief Executive Officer	1.00
Executive Assistant II	1.00
Executive Assistant, Board of Directors	1.00
<b>Grand Total</b>	<b>3.00</b>

## Business Leadership

### 2026-2027 Budget

#### Expenses

Salaries	1,519,645
Benefits	303,929
<b>Total Salaries and Employee Benefits</b>	<b>1,823,574</b>
Program Materials & Supplies	13,000
Education, Conferences & Workshops	59,174
Team Building	6,200
Travel & Subsistence	34,963
Media / Advertising	19,000
Memberships & Dues	500
Clinical Travel	5,000
Clinical Consultation	400,000
Clinical Contracts / Services	100,000
Office Materials & Supplies	500
Software & Subscription	43,200
Professional Consulting / Services	10,000
<b>Total Program Expenses</b>	<b>691,537</b>
<b>Total Expenses</b>	<b>2,515,111</b>

#### Position Name

#### FTE

Director, People and Culture	1.00
Executive Assistant	1.00
Manager, Marketing	1.00
Director, Corporate and Community Relations	1.00
Director, Clinical (Inclusivity and Indigenous Initiatives)	1.00
Implementation Lead	1.00
Executive Assistant II	1.00
Director, Clinical (Interprofessional Practice and Support Services)	0.90
Executive Assistant I	0.50
Director, Clinical (Classrooms)	1.00
Director, Clinical (Day Programs and House)	1.00
Executive Assistant I	0.50
Medical Affairs Coordinator	1.00
<b>Grand Total</b>	<b>11.90</b>

# Business Intelligence and Evaluation

## Who we help

The Business Intelligence and Evaluation department serves all CASA programs/departments, leadership teams and the Board of Directors by providing accurate, timely and actionable data to inform decisions and evaluate outcomes. The department also leads quality improvement efforts, including accreditation, and promotes a strong culture of quality.

## How we help

The Business Intelligence and Evaluation department provides improvement, evaluation and data-driven insights through the development of logic models, evaluation frameworks, dashboards, reports and process maps. The team ensures data is accurate, reliable, and used effectively to track performance, monitor outcomes and drive organizational impact.

## What happens in the service

The Business Intelligence and Evaluation team:

- Develops and maintains data governance frameworks;
- Identifies, monitors and reports on key performance indicators (KPIs) and targets at the clinical program and organizational level through reports and dashboards;
- Conducts program evaluations (formative and outcome);
- Prepares internal and external reports for various audiences;
- Ensures readiness for accreditation; and
- Develops and implements processes for quality assurance and improvement.

## Who delivers the service

This service is delivered by a multidisciplinary team of a manager, data governance lead, evaluation and data analysts (4), business intelligence analyst, quality improvement lead, quality and continuous improvement specialist and research assistant.

- **Data Strategy and Governance Lead**
  - Ensures CASA's data strategy and governance frameworks align with organizational goals and objectives
  - Supports IT transformation projects, including CASA's effort to clean up shared network drives in preparation for migration to SharePoint
- **Evaluation and Data Analysts**
  - Collaborate with clinical teams to develop program-specific logic models and evaluation frameworks
  - Conduct regular data quality checks and address gaps in data availability
- **Business Intelligence Analyst**
  - Collaborates with clinical and business teams to assess needs and create customized dashboards that provide actionable insights and support informed decision-making
- **Quality Improvement Lead and Quality Improvement Specialist**
  - Collaborate with business and clinical leaders and staff to drive a culture of quality across the organization
  - Lead the organization's accreditation cycle
- **Research Assistant**
  - Supports data entry and data collection activities, and other tasks as needed

## How we connect across CASA

The Business Intelligence and Evaluation team attends various program team meetings and cross-departmental working groups to collaborate on quality improvement, evaluation and data needs, and to share insights through internal presentations. The team also collaborates with the Accreditation Council to support accreditation planning and preparation.

## How we measure success

Success is measured through qualitative and quantitative indicators that reflect the value and impact of the team's work. These include:

- Percentage of programs with a defined logic model and evaluation framework;
- Response rates on program evaluation measures and surveys;
- Patient/family feedback from surveys;
- Number and turnaround time of ad hoc requests;
- Number of internal and external reports completed;
- Number of dashboards launched;
- Frequency of data quality checks and audits conducted;
- Number of presentations delivered on data governance, quality improvement and evaluation needs;
- Number of standardized data collection tools or processes implemented across programs;
- Frequency of decisions and actions resulting from Business Intelligence and Evaluation insights;
- Percentage of accreditation criteria met;
- Number of process mapping sessions facilitated; and
- Number of research collaborations, presentations, and publications.

## Metrics

<b>Ad-hoc data/quality improvement requests completed (April 2025-January 2026)</b>	105 (~10 per month)
<b>Dashboards launched to date</b>	8
<b>Process mapping activities completed to date</b>	4

## 2026-2027 Budget

### Expenses

Salaries	690,105
Salaries - Casuals	50,000
Benefits	138,021
<b>Total Salaries and Employee Benefits</b>	<b>878,127</b>
Program Materials & Supplies	7,150
Education, Conferences & Workshops	14,802
Team Building	900
Travel & Subsistence	2,000
Office Materials & Supplies	2,000
IT Materials & Supplies	3,000
Software & Subscription	3,090
<b>Total Program Expenses</b>	<b>32,942</b>
<b>Total Expenses</b>	<b>911,069</b>

### Position Name

Business Intelligence Analyst	2.00
Data Strategy and Governance Lead	1.00
Evaluation and Data Analyst	4.00
Manager, Business Intelligence and Evaluation	1.00
<b>Grand Total</b>	<b>8.00</b>

# Communications

## Who we serve

CASA Communications serves an internal client group of all clinical and business operations departments, as well as senior leadership, the board of directors and the broader staff audience. Externally, we serve many diverse audiences, including donors and potential supporters, social media followers, website visitors, traditional media outlets, community partners and funders, and – ultimately – CASA patients and families.

## How we help

CASA Communications supports programs, services and departments as the go-to resource to communicate clearly and confidently. The department develops communications strategies and provides a variety of other services to help meet the objectives of organizational projects and priorities, including the distribution of internal and external messaging. We can help you communicate with your intended audience to achieve CASA's strategic goals.

## The overarching goals of the Communications team are to:

- Build trust and enhance CASA's reputation;
- Tell stories about impact;
- Support CASA people and programs; and
- Provide tools and resources for staff to communicate.

## What happens in the service

The Communications team provides a wide variety of services for CASA, including:

- Communicating CASA's strategic priorities through professional storytelling;
- CASA's visual identity and requests from vendors related to CASA's logo and brand;
- Communications strategy templates, support and strategizing the best ways to communicate information;
- Writing/editing/formatting services, including grammar and Canadian Press Style;
- Inclusive language questions or comments;
- Developing, designing, optimizing and printing presentations and other documents;
- Branded materials for events (banners, tablecloths, flags and printed material);
- CASA Connect, the Connector newsletter and external website management;
- Circle of Care, CASA's podcast and quarterly external newsletter;
- Social media channel management, policies and strategies;
- Media releases for events or programs;
- Responding to external media and public information requests; and
- Communications-related training, resources and policy management.

## Who delivers the service

The CASA Communications team comprises a manager, a graphic designer, three specialists assigned to CASA departmental portfolios and two coordinators assigned to manage CASA's various communications channels. The manager reports to the Director, Corporate and Community Relations, who is the link between senior leadership and the Communications team to ensure alignment with CASA priorities and other parts of the portfolio and organization.

## How we connect across CASA

Communications uses a request form for internal clients to request support. This process allows the team to triage requests and complete projects in a timely manner. It also helps with task tracking, sharing of workloads and resource decision making.

Communications strategies, tactics and team members extend throughout the organization on a daily basis, by working with internal clients and sharing information through the many channels and tactics identified above. The director, manager and communications specialists are embedded into most organizational committees, councils and leadership meetings to support information flow, strategic planning and effective communication.

### How we measure success

Communications tracks monthly metrics related to internal communications request forms, website traffic, social media following and engagement, info@ requests, newsletter readership, media outcomes and measurable objectives embedded in each communications strategy.

### Target service volume

Communications currently receives and manages between 100 and 200 intake form requests from staff each month, and aims to respond to and address 100 per cent of those.

<b>2026-2027 Budget</b>	
<b>Expenses</b>	
Salaries	682,361
Benefits	136,472
<b>Total Salaries and Employee Benefits</b>	<b>818,833</b>
Program Materials & Supplies	22,000
Education, Conferences & Workshops	13,647
Team Building	800
Travel & Subsistence	5,000
Office Materials & Supplies	2,000
Software & Subscription	52,400
Media / Advertising	10,000
Professional Consulting / Services	10,000
Memberships & Dues	3,500
<b>Total Program Expenses</b>	<b>119,347</b>
<b>Total Expenses</b>	<b>938,180</b>

<b>Position Name</b>	<b>FTE</b>
Communications Coordinator	2.00
Communications Specialist	4.00
Graphic Designer	1.00
Manager, Communications	1.00
<b>Grand Total</b>	<b>8.00</b>

# Facilities

## Who we serve

The CASA Facilities department serves a wide range of careholders, including clinical programs, business operations and our patients and families. Our primary role is to create and maintain a safe, functional and therapeutic environment that supports patient care and employee well-being. By ensuring that buildings, equipment and spaces are properly maintained, compliant with health and safety regulations and conducive to healing, the facilities department enables our professionals to focus on delivering quality mental health services while promoting comfort, privacy and respect for all our guests.

## How we help

Facilities assists by offering the following comprehensive services:

- Preventative and corrective maintenance;
- Space planning and utilization;
- Energy management;
- Health and safety compliance;
- Waste management;
- Cleaning and janitorial services;
- Security and access control; and
- Vendor management and procurement.

## What happens in the service

Facilities personnel identify categories of work by organizing activities that ensure a building operates efficiently, safely and sustainably. Key areas include:

- Maintenance Management: focuses on preventive and corrective upkeep of systems and equipment.
- Space Management: optimizes the use and allocation of physical space to meet organizational needs.
- Safety and Compliance: ensures buildings meet health, safety and regulatory standards.
- Asset Lifecycle Management: tracks and manages assets from acquisition to disposal to maximize value and performance.

Together, these categories help us align operations with organizational goals while maintaining a safe and productive environment for our employees, patients, and families.

## Who delivers the service

Services are delivered by the Facilities Manager, Facilities Coordinator and/or third party vendors.

## How we connect across CASA

The Facilities department provides support for all CASA sites across Alberta, providing various site-specific services as needed.

We offer daily support and inquiry responses to our employees through the CASA Service Portal.

## How we measure success

Success in the Facilities department is measured using a set of key performance indicators: financial performance; operational efficiency; occupant satisfaction; and sustainability/compliance.

## Service Volume To Date

Metric	August 2025 – January 2026
Service desk tickets	506
Average first response time	5 hours 45 min
Average resolution time	13 hours

## 2026-2027 Budget

### Expenses

Salaries	163,724
Benefits	32,745
<b>Total Salaries and Employee Benefits</b>	<b>196,469</b>
Program Materials & Supplies	10,000
Education, Conferences & Workshops	3,274
Team Building	200
Travel & Subsistence	4,000
Facilities Repairs & Maintenance	258,194
Facilities Maintenance Service Contracts	91,240
Janitorial / Snow Removal	204,000
Utilities	84,000
Insurance	215,883
Facility Lease	632,649
Occupancy Costs	156,401
Office Materials & Supplies	3,000
Waste	15,000
Software & Subscription	19,985
Other Services & Rentals	27,100
Memberships & Dues	600
<b>Total Program Expenses</b>	<b>1,725,526</b>
<b>Total Expenses</b>	<b>1,921,995</b>

### Position Name

Manager, Facilities	1.00
Facilities Coordinator	1.00
<b>Grand Total</b>	<b>2.00</b>

# Finance

## Who we serve

The finance team supports CASA both internally and externally. Internally, we provide support by providing budget reporting for financial insight into all departments as well as provide guidance so budget holders can make operational decisions. We also support CASA by providing overall reporting for our Board and SLT members to support big picture strategic initiatives. We also provide reporting for our external partners by including government and community grants to ensure we meet our obligations to outside funders.

## How we help

The finance team helps serve the CASA mission by ensuring that our work and reporting upholds our mission to be a fiscally responsible organization and to ensure that funds received by CASA are used responsibly.

## What happens in the service

**General Accounting** - internal control setting, audit preparedness, policy and procedure review and recommendation. Yearly budget setting and forecasting support, special projects tracking. Internal tracking and reconciliation of capital expenses including asset purchase and disposition and liability accuracy.

**Financial reporting** - both internal and external reporting, including monthly budget reports and organizational financial statements. Alberta Gaming, Liquor and Cannabis, Canada Revenue Agency, Government of Alberta and Alberta Health Services external reporting. Yearly external audit reporting, special projects tracking.

**Accounts receivable/payable** - revenue tracking and reconciliation throughout the organization based on source and external requirements. Deferred, restricted and government funding classification and recognition. Special projects and dashboard information creation. Expense tracking and coding review and support, approval tracking. Payment processing, tracking of corporate credit cards.

**Payroll** - Payroll processing and liability reconciliation, Canada Revenue Agency reporting, pension and union reporting.

## Who delivers the service

Financial Analysts (2)

Intermediate Accountant

Team lead - Financial Reporting

Accounts Payable Coordinators (2)

Payroll Coordinators (2)

Manager, Finance

Director of Finance

## How we connect across CASA

- Monthly budget meetings with organizational budget holders;
- Special projects specific tracking meetings.

## How we measure success

- Maintaining budget vs. actual;
- Favorable audit report;
- Maintaining reporting timelines for internal and external reporting; and
- Timely payment processing.

## 2026-2027 Budget

### Expenses

Salaries	920,130
Benefits	184,026
<b>Total Salaries and Employee Benefits</b>	<b>1,104,157</b>
Education, Conferences & Workshops	18,403
Team Building	1,000
Travel & Subsistence	1,000
Office Materials & Supplies	2,000
Software & Subscription	29,000
Liability Insurance	60,232
Accounting / Audit Fees	50,000
Bank Fees	25,000
Professional Consulting / Services	5,000
Memberships & Dues	5,000
<b>Total Program Expenses</b>	<b>196,634</b>
<b>Total Expenses</b>	<b>1,300,791</b>

### Position Name

### FTE

Accounts Payable Administrator	2.00
Director, Finance	1.00
Financial Analyst, Payroll and Reporting	1.00
Financial Analyst, Revenue and Philanthropy Support	1.00
Intermediate Accountant	1.00
Lead, Financial Reporting, Budgeting and Forecasting	1.00
Manager, Finance	1.00
Payroll Coordinator	2.00
<b>Grand Total</b>	<b>10.00</b>

# Inclusion, Diversity, Equity and Accessibility

## Who we serve

In alignment with CASA's organizational vision, mission and values, the IDEA (Inclusion, Diversity, Equity and Accessibility) team works daily to embed the principles of inclusion, diversity, equity and accessibility into every aspect of the organization. Our work includes:

- Embedding IDEA principles and their integration into all aspects of CASA's work. Reviewing and refining policies, practices, and procedures to ensure they align with IDEA values.
- Identifying gaps and areas of improvement and providing actionable recommendations for systemic change.
- Supporting the continuous growth of IDEA knowledge across the organization through leadership, training, development and collaborative learning.

## How we help

The IDEA team plays a critical role in advancing CASA's vision to become both an equitable workplace and a leading provider of culturally responsive mental health services. As a strategic arm of the organization, the IDEA team is committed to ensuring every individual within CASA regardless of role, background or identity feels respected, valued and empowered. Our approach prioritizes addressing the needs of historically marginalized groups, such as those with mental health challenges, women, Indigenous peoples, racialized minorities, persons with disabilities and the 2SLGBTQIA+ community. At the same time, we aim to remove barriers and promote true inclusion for all individuals within CASA, celebrating the diversity of experiences across the organization.

The IDEA team at CASA is not just a department, but a strategic business arm that drives organizational excellence and inclusion across all levels. Our leadership and commitment to embedding IDEA principles into every facet of CASA's work ensures that we remain a forward-thinking, inclusive organization.

## Our Impact: A Holistic Approach to Inclusion and Accessibility

The IDEA team's work is integral to advancing CASA's strategic objectives of fostering a safe, inclusive, diverse and accessible workplace while also providing mental health services that are sensitive to the cultural and individual needs of the populations we serve. We embed IDEA values within every facet of our organizational strategy, with measurable impact across several key dimensions:

- Psychological Safety: Ensuring a supportive environment where all individuals feel safe to express their thoughts and experiences without fear of judgment or reprisal.
- Equitable and Inclusive Services: Guaranteeing that our mental health services are accessible and culturally sensitive to all, with a focus on reducing disparities.
- Individuality and Community: Supporting both individual growth and a strong sense of community, creating spaces where all voices are heard and valued.
- Relationships: Strengthening interpersonal connections that promote trust, respect and collaboration.
- Accessibility: Removing physical, digital and systemic barriers to participation and engagement.
- Experiences: Shaping positive and equitable experiences for everyone involved in CASA's services.
- Demographics: Recognizing and addressing the diverse needs of all individuals who interact with CASA, ensuring their voices influence decision-making.
- Environment: Designing spaces, both physical and organizational, that reflect our commitment to inclusion and accessibility.

## What happens in the service

Our work is aligned with CASA's core values, ensuring that everyone in our organization feels safe and empowered to contribute to an inclusive and accountable environment. We lead this transformation through a multifaceted approach, addressing challenges and opportunities across the following dimensions:

**Individual Level:** Personalized coaching, reflexivity and dialogue to promote growth and self-awareness, that is specifically built to target people leaders.

**Organizational Level:** Identifying systemic barriers and opportunities to foster structural changes that promote inclusion and accessibility across all departments. Listening to the needs of those around us and building partnerships that drive shared impact.

**Society Level:** Advocating for systemic change and leading by example in the broader mental health and health-care landscape.

## Who delivers the service

The IDEA team comprises a manager, two IDEA partners and a coordinator. Members of the IDEA team hold at minimum a bachelor's degree in a humanities, social services or education-related field.

## How we connect across CASA

The IDEA team at CASA is not just a department, but a strategic business arm that drives organizational excellence and inclusion across all levels. Our leadership and commitment to embedding IDEA principles into every facet of CASA's work ensures that we remain a forward-thinking, inclusive organization.

The IDEA team is in the process of developing a comprehensive organizational strategic plan that will serve as CASA's roadmap for transformative cultural change. This plan will outline specific actions, goals and metrics to drive IDEA implementation across all areas of the organization. Our strategic plan will be executed through six interconnected pillars, each focused on a critical area of organizational transformation:

**Thriving Communities (Who We Are and Who We Serve):** Building a diverse, supportive and equitable community within CASA, ensuring that we serve all individuals with dignity and respect.

**Responsive Services (What We Do):** Delivering mental health services that are culturally competent and responsive to the unique needs of the diverse populations we serve.

**Reciprocal Relationships (How We Connect):** Cultivating meaningful, collaborative relationships across all levels of the organization and with external partners to advance shared goals.

**Knowledge Generation (How We Grow):** Leading research, education and training efforts that promote the continuous growth of IDEA knowledge within CASA and the broader community.

**Inclusive Spaces (Where We Gather):** Creating physical and digital environments that are welcoming, accessible and conducive to collaboration and innovation.

**Accountable Leadership (How We Sustain Momentum):** Fostering accountable leadership at every level to ensure the long-term sustainability of our IDEA initiatives and to maintain a culture of continuous improvement.

## How we measure success

We measure success through:

- number of requests received;
- number of events delivered and satisfaction of events delivered (85 per cent rate);
- use of change plans that include an IDEA assessment or consultation;
- number of IDEA policies and practices reviewed;
- number of underrepresented groups covered;
- number of geographic; and
- number of programs (100 per cent rate).

## Target service volume

Recent service volumes and statistics from the IDEA team include:

- 166 partnerships for support in 2025. The most common requests were for training and professional development, mostly from our Classrooms teams, support of managers and consultations on policies, processes and patient care.

- Since 2024, IDEA has trained more than 200 staff through the CASA 101 process and have consistently been rated as a top valuable session by our new staff (166 per cent more often than the next most frequently mentioned session).
- Ninety-five per cent of respondents indicated they were very satisfied or satisfied with the Learning Day and 81.3 per cent of respondents indicated that the content at the Learning Day was very helpful or helpful to their learning.

## 2026-2027 Budget

### Expenses

Salaries	319,472
Benefits	63,894
<b>Total Salaries and Employee Benefits</b>	<b>383,366</b>
Program Materials & Supplies	14,000
Education, Conferences & Workshops	6,389
Team Building	300
Travel & Subsistence	4,000
Office Materials & Supplies	2,000
Software & Subscription	3,000
Other Services & Rentals	61,000
Professional Consulting / Services	90,000
<b>Total Program Expenses</b>	<b>180,689</b>
<b>Total Expenses</b>	<b>564,056</b>

### Position Name

### FTE

Inclusion, Diversity, Equity and Accessibility (IDEA) Partner	2.00
Manager, Inclusion, Diversity, Equity and Accessibility (IDEA)	1.00
<b>Grand Total</b>	<b>3.00</b>

# Information Technology

## Who we serve

The Information Technology (IT) department supports all employees who rely on technology to perform their work and deliver care across CASA programs. The service also supports external partners when their work requires access to CASA systems.

## How we help

Information Technology ensures employees have safe, reliable and secure technology so they can provide high-quality care and run programs efficiently.

The service reduces risk by maintaining stable systems, protecting sensitive information, and ensuring timely support. It adds value by improving workflow efficiency, enabling data-informed decisions, supporting high-quality care, and ensuring the organization can grow and adapt through modern and scalable technology.

## What happens in the service

### Infrastructure Management

- Maintain networks, servers, cloud systems and core applications.
- Monitor system health, update systems and perform regular backups.
- Support business continuity planning and recovery after an incident.

### Cybersecurity Support

- Monitor systems for risks and respond to security events.
- Maintain safe access to systems and protect organizational technology assets.
- Support organization-wide cybersecurity awareness activities.

### Service Desk and Device Management

- Provide day-to-day technology support through the service portal.
- Support staff computers, tablets, printers and mobile devices.
- Employee onboarding and offboarding support and workflow management.

### Technology Governance and Planning

- Develop technology standards and support compliance with privacy and security expectations.
- Plan for future technological needs, new locations and program expansion.
- Manage hardware and software lifecycle activities and major upgrades.

## Who delivers the service

The service is delivered by a team with skills in technical support, systems operations, network management, cybersecurity, risk management and technology planning. Core competencies include troubleshooting, customer service, system administration, secure system design, project delivery and risk reduction. Roles include:

- **IT support analysts**  
Provide frontline support to staff, resolving technology issues and managing user access, devices and service requests. Enable smooth day-to-day operations and escalate complex issues when needed.
- **IT cloud systems engineer**  
Maintains and optimizes cloud platforms and digital workplace systems. Ensures secure access, manages automation, supports identity and device management, and improves cloud-based services across the organization.
- **IT infrastructure engineer**  
Maintains networks, servers, connectivity and on-premises infrastructure. Ensures system performance, monitoring, backups and security controls are in place to keep all systems stable and reliable.

- **IT manager**

Leads the overall technology function, ensuring stable systems, secure operations and effective governance. Guides long-term planning, oversees cybersecurity and cloud platforms, and supports the team in delivering consistent service.

## How we connect across CASA

Information Technology works with every department through daily support interactions and shared operational workflows. The team collaborates with programs and leaders to plan for new locations, technology changes, and emerging organizational needs. IT participates in planning groups related to security, digital tools and operations, and partners closely in onboarding and offboarding processes, system access management, incident reporting, asset tracking and service improvement activities. The team also supports organization-wide initiatives such as new office openings, system improvements, communication system modernization and technology refresh projects, ensuring that technology is integrated smoothly into all aspects of CASA's work.

## How we measure success

Information Technology measures success by monitoring system availability, response and resolution times for service requests, and overall adherence to service level expectations. Progress is also evaluated through reductions in cybersecurity risks, timely completion of device lifecycle activities and employee satisfaction with technology tools and support. The team's effectiveness is further demonstrated through the successful delivery and adoption of major technology improvements.

Metric	2025 – 2026
Service desk tickets	7,542
New user onboardings/offboardings	~410
Hardware lifecycle replacements	315
Major infrastructure upgrades	6
Average first response time	2 hours (down from 8 hours)
Requests resolved within service expectations	96%
Average resolution time	5.5 hours
Customer satisfaction rating	98% (industry average 84%)

## 2026-2027 Budget

### Expenses

Salaries	424,047
Benefits	84,809
<b>Total Salaries and Employee Benefits</b>	<b>508,857</b>
Education, Conferences & Workshops	8,481
Team Building	500
Travel & Subsistence	7,000
Office Materials & Supplies	1,000
Copier Usage	65,158
Telephone & Communications	439,286
Copier / Office Equipment Rental	18,000

IT Materials & Supplies	150,000
Software & Subscription	638,000
IT Maintenance & Support	25,000
Professional Consulting / Services	90,000
<b>Total Program Expenses</b>	<b>1,442,425</b>
<b>Total Expenses</b>	<b>1,951,282</b>

<b>Position Name</b>	<b>FTE</b>
IT Network Administrator	2.00
IT Support Specialist	2.00
Manager, Information Technology	1.00
<b>Grand Total</b>	<b>5.00</b>



# Occupational Health and Patient Safety

## Who we serve

CASA's Occupational Health and Patient Safety (OHPS) team serves all CASA employees, physicians, students, volunteers, contractors, patients and families. We support staff by ensuring safe, compliant and healthy workplaces, and we protect patients by fostering care environments where safety, trust and well-being come first.

## How we help

We take a proactive approach to health and safety through prevention, education and collaboration. Our team develops policies, delivers training and conducts assessments to identify risks early, promote wellness and maintain a culture of safety across all CASA sites and programs.

## What happens in the service

The OHPS team provides hands-on support through workplace inspections, ergonomic assessments and duress and emergency preparedness activities. We manage incident reporting and investigations, lead safety and infection control training, and guide staff in implementing best practices that protect both staff and patients. We create and respond to organizational needs by creating comprehensive systems and programs, including but not limited to CASA's Safety Incident Management System (SIMS), the Work From Home Program, Ergonomics Program and Fall Prevention Program.

## Who delivers the service

Our multidisciplinary team includes:

- **Occupational Health and Safety Advisor:**  
Partners with teams to build a safe and healthy workplace by proactively identifying risks, supporting safe practices and caring for the well-being of all employees.
- **Patient Safety Advisor:**  
Partners with care teams and families to strengthen patient safety by learning from incidents and experiences, promoting best practices and supporting safer, higher-quality care.
- **Manager, Occupational Health and Patient Safety:**  
Partners across the organization to lead and strengthen employee and patient safety, aligning people, practices and compliance to foster a shared culture of safety and continuous improvement.

Together, they ensure safety principles are integrated into every level of CASA operations and care delivery.

## How we connect across CASA

OHPS partners with programs and departments across CASA to embed safety practices into daily operations. We provide consultation, training and data insights that inform decision-making, strengthen accountability and support CASA's shared commitment to safe, high-quality care. The team connects with employees and leaders across the organization through the safety incident management system, which was designed specifically for CASA's needs, making it easy to report concerns, learn from incidents and take meaningful action to improve safety for everyone.

## How we measure success

We measure success through compliance with safety standards, reductions in workplace injuries and incidents, and continuous improvement in patient safety outcomes. Feedback, audit results and data-driven analysis guide our ongoing efforts to enhance safety culture and performance.

Quantitatively we use safety incident management system data to ensure incidents are submitted and reviewed within the required timeline.

Qualitatively, through employee engagement and accreditation surveys, we measure CASA's safety culture by monitoring knowledge and adherence to safety protocols as well as overall feeling of safety.

Metric	Target
Average time to review incidents	<7 days
Correct incident classification by staff	65%
Patient Safety - No Blame Culture	70%
Employee Safety Rating	70%

## 2026-2027 Budget

### Expenses

Salaries	441,025
Benefits	88,205
<b>Total Salaries and Employee Benefits</b>	<b>529,231</b>
Program Materials & Supplies	160,000
Education, Conferences & Workshops	8,821
Team Building	500
Travel & Subsistence	9,500
Office Materials & Supplies	2,500
Medical/Safety Equipment Repairs & Maintenance	23,000
Software & Subscription	34,000
Professional Consulting / Services	22,000
Memberships & Dues	1,000
<b>Total Program Expenses</b>	<b>261,321</b>
<b>Total Expenses</b>	<b>790,551</b>

### Position Name

### FTE

Manager, Occupational Health and Patient Safety	1.00
Occupational Health and Safety Advisor	2.00
Patient Safety Advisor	1.00
OHPS Coordinator	1.00
<b>Grand Total</b>	<b>5.00</b>

# People and Culture

## Who we serve

The People and Culture department serves CASA employees, leadership, students and candidates.

## How we help

The People and Culture team partners with leadership to support a healthy, effective and values-aligned organization. We operate as a trusted and strategic partner, supporting leaders and employees through strong relationships, people-centred practices and a focus on culture and trust. We support leaders and teams at every stage of the employee and student experience, from entry to exit, helping leaders make informed, people-focused decisions that strengthen the employee experience and organizational effectiveness.

## What happens in the service

The People and Culture team functions in and supports the organization with six main pillars, which are:

- **Compensation and benefits:**  
Designing and administering fair, competitive compensation and benefits programs that support attraction, retention and wellbeing.
- **Recruitment and staffing:**  
Supporting workforce planning, recruitment and selection to ensure the right people are in the right roles at the right time.
- **Training and development:**  
Supporting learning, onboarding and leadership development that build capability and confidence across the organization.
- **Labour and employee relations:**  
Providing guidance and support on employee relations matters, performance conversations and workplace concerns, including union-related issues.
- **Employee experience:**  
Supporting a positive, inclusive employee experience through engagement, culture, wellbeing and day-to-day people practices.
- **Compliance and labour laws:**  
Ensuring organizational practices align with employment legislation, collective agreements and internal policies.

Together, these pillars reflect how we support CASA, not just through processes and systems, but through people, relationships and trust.

## Who delivers the service

People and Culture services are delivered by a multidisciplinary team that works collaboratively across all six pillars.

The team includes People and Culture business partners, coordinators, an employee engagement coordinator, a talent acquisition specialist, a student placement coordinator, an organizational development lead and a manager. While team members bring different areas of expertise, we operate as an integrated team, partnering closely with leaders and employees to provide consistent, coordinated, and people-centred support.

This approach allows us to respond to individual needs while maintaining alignment, continuity and shared accountability across the People and Culture function.

## How we connect across CASA

The People and Culture team builds relationships across every level of the organization and supports people leaders throughout CASA. We work in partnership with programs, services and leadership to align people practices with organizational goals, values and culture.

Leaders typically connect with People and Culture through regular touchpoints and consultations, onboarding and orientation (CASA 101), training and facilitated workshops, and one-on-one support including coaching and leadership development.

Through these connections, we partner with programs, services and leadership to align people practices with organizational goals, values and culture, ensuring they are consistent, responsive and grounded in trust.

## How we measure success

We use a mix of qualitative and quantitative tools to track the impact of our People and Culture work and make sure leaders and employees are supported in meaningful ways. This includes engagement and retention metrics, recruitment and onboarding performance, and feedback from surveys like 30-day check-ins and CASA 101. These insights help us continuously improve our services and demonstrate the value of our work across the organization.

## Service Volume to Date

Metric	Result
YTD number of recruitment requisitions	195
YTD # of new employees onboarded	137
YTD # of employee resignations	44
Voluntary turnover rate	8.3%
YTD # of people who have attended CASA 101	150
YTD # of student placements	37
YTD average time to fill	33 Days
2024 employee engagement score	84%

## 2026-2027 Budget

### Expenses

Salaries	1,169,671
Benefits	233,934
Other Benefits - Employee Assistance Program	24,000
<b>Total Salaries and Employee Benefits</b>	<b>1,427,605</b>
Program Materials & Supplies	200
Education, Conferences & Workshops	23,393
Team Building	120,100
Travel & Subsistence	8,000
Office Materials & Supplies	200
Software & Subscription	235,117
Staff Recruitment	361,000
Legal Fees	100,000
Other Services & Rentals	3,500
Professional Consulting / Services	100,000
Memberships & Dues	2,500
<b>Total Program Expenses</b>	<b>954,010</b>
<b>Total Expenses</b>	<b>2,381,615</b>

<b>Position Name</b>	<b>FTE</b>
Project Manager, HRIS	1.00
Student Placement Coordinator	1.00
Manager, People and Culture	1.00
People and Culture Business Partner	3.00
Organizational Development Lead	1.00
Talent Acquisition Specialist	2.00
People and Culture Coordinator	3.00
Employee Engagement Coordinator	1.00
<b>Grand Total</b>	<b>13.00</b>



# Philanthropy

## Who We Serve

The Philanthropy department serves the entire organization by securing resources, building partnerships and strengthening CASA's reputation and reach.

In serving CASA, we also partner closely with:

- Internal teams who rely on philanthropic support to enhance and sustain care.
- Community partners, donors and corporations that invest in CASA's mission.
- Volunteers, ambassadors and event participants who help build awareness and advocacy.

Ultimately, by serving CASA Mental Health as our primary client, we support children, youth and families who depend on the programs we resource.

## How We Help

Philanthropy ensures CASA has the resources and relationships needed to fulfill its mission to build resilience through holistic, evidence-informed and compassionate care, and to advocate for children, youth and families with mental illness.

Our work:

- Secures and diversifies funding to complement and extend government investment;
- Strengthens CASA's reputation and visibility, building public trust in mental health services;
- Fosters partnerships with donors, businesses and community organizations that bring expertise, volunteers and resources to CASA;
- Mitigates risk by reducing dependency on any single funding source and ensuring sustainability for programs not fully funded by government; and
- Amplifies CASA's impact by aligning philanthropic goals with clinical priorities and expansion initiatives.

## What Happens in the Service

Philanthropy designs and delivers comprehensive strategies to engage and sustain community investment across Alberta. Key areas of work include:

- Fundraising Strategy and Campaign Management: Major gifts, capital campaigns, community and corporate giving, events, planned giving and grants.
- Donor Stewardship and Recognition: Building long-term relationships through meaningful communication, reports, naming opportunities and recognition.
- Events and Community Engagement: Hosting signature events, third-party fundraisers and awareness activities that connect people to CASA's mission.
- Storytelling and Impact Reporting: Collaborating with Communications to share stories of impact that demonstrate accountability and inspire giving.
- Prospect Development and Research: Identifying new funding opportunities aligned with CASA's priorities.
- Strategic Partnerships: Developing collaborations with corporations, foundations and community groups to advance mental health initiatives.

## Who Delivers the Service

The Philanthropy Department is staffed by professionals with specialized skills in relationship management, fundraising, communications and strategy. Competencies required include strategic communication, donor engagement, ethical fundraising (AFP Code of Ethics), financial management and relationship-building.

**Key roles include:**

### Director of Philanthropy:

Leads the department, aligns strategy with CASA's mission and manages major donor relationships and campaign execution.

## Manager, Philanthropy and Donor Engagement:

Oversees signature and community events, annual giving, stewardship, marketing, grants and data.

## Manager, Philanthropy and Strategic Partnerships:

Leads major gifts, partnerships and regional expansion fundraising.

## Regional philanthropy officers (Calgary, Fort McMurray, Medicine Hat, Edmonton):

Build CASA's presence and donor base across Alberta.

## Philanthropy officers and coordinators:

Support events, stewardship, data and reporting, marketing and administrative functions.

## How We Connect Across CASA

Philanthropy operates as a cross-organizational partner to advance CASA's mission.

We collaborate with:

- **Communications:** on storytelling, branding and public engagement.
- **Clinical and program teams:** to identify funding priorities, highlight impact and align donor investments with care needs.
- **Finance:** to ensure transparency and accountability in reporting and use of funds.
- **Project Management Office:** on campaign planning, tracking deliverables and coordinating across departments.
- **Capital Expansion Team:** to secure gifts for new CASA House builds, donor recognition opportunities and grand opening events.
- **CEO and senior leadership team:** to ensure philanthropic strategies reflect CASA's organizational goals.
- **Volunteers and ambassadors:** to help expand reach and advocacy, and support fundraising events and initiatives.

## How We Measure Success

Philanthropy measures both financial and relationship-driven outcomes, ensuring accountability and long-term impact.

**Key indicators include:**

- Funds raised: annual and campaign revenue targets.
- Diversified revenue streams: multiple vehicles to support annual fundraising goals.
- Donor acquisition, retention and growth: year-over-year giving trends and engagement rates.
- Return on investment (ROI): comparison of fundraising costs to dollars raised.
- Donor satisfaction and stewardship metrics: based on engagement touchpoints and feedback.
- Community reach and awareness: participation in events and campaign reach.
- Alignment with CASA mission: funding priorities achieved and programs supported.

## Target Service Volume

### Philanthropy activities and outputs:

- \$4.7M fundraising target (2025-26): \$3M operational + \$1.7M capital.
- \$11.49M fundraising target (2026-27): \$3M operational + \$8.49M capital.
- \$23.7M fundraising target (2027-28): \$3M operational + \$20.7M capital.
- \$29.6M fundraising target (2028-29): \$3M operational + \$26.6M capital.
- \$20.94M fundraising target (2029-30): \$3M operational + \$17.94M capital.

### 2025-26 Activities:

- 30+ grant applications submitted annually.
- 400+ active donor relationships cultivated, solicited and stewarded annually.
- 20+ signature and community events executed per year.
- 50+ CASA Ambassadors recruited to support campaign goals.
- Donor impact reports distributed to key partners.

## 2026-2027 Budget

### Expenses

Salaries	1,352,984
Benefits	270,597
<b>Total Salaries and Employee Benefits</b>	<b>1,623,580</b>
Program Materials & Supplies	1,500
Education, Conferences & Workshops	27,060
Team Building	1,500
Travel & Subsistence	10,000
Office Materials & Supplies	1,000
Software & Subscription	30,000
Media / Advertising	50,000
Bank Fees	14,000
Stewardship	30,000
Scholarship	4,500
Annual Giving	200,000
Community Fundraising	15,000
Major Gifts	60,000
Gaming	1,000
Mid-Level Giving	2,500
Planned Giving	9,000
Signature Events	447,000
Capital Expansion	1,267,000
<b>Total Program Expenses</b>	<b>2,171,060</b>
<b>Total Expenses</b>	<b>3,794,640</b>

### Position Name

	<b>FTE</b>
Executive Assistant I	1.00
Manager, Philanthropy	1.00
Philanthropy Officer, Annual Giving	1.00
Philanthropy Officer, Community Fundraising	1.00
Philanthropy Officer, Data and Reporting	1.00
Philanthropy Officer, Marketing	1.00
Director, Philanthropy	1.00
Philanthropy Officer, Donor Experience	1.00
Philanthropy Officer, Engagement and Events	1.00
Philanthropy Officer, Meaningful Giving	2.00
Manager, Philanthropy and Strategic Partnerships	1.00
Philanthropy Officer, Transformational Giving	1.00
Philanthropy Officer, Fort McMurray	1.00
Philanthropy Officer, Calgary	1.00
<b>Grand Total</b>	<b>15.00</b>

# Privacy and Health Information

## Who we serve

Privacy and Health Information serves all CASA programs and departments that access CASA information and resources to complete their work. The team also serves external providers, third parties and patients and families through multiple avenues.

## How we help

Privacy and Health Information provides assistance with collecting, using, accessing, managing, protecting and disclosing CASA information. The service supports programs and departments in managing the records lifecycle of information and ensures retention and disposition schedules are implemented.

## What happens in the service

This service supports patients, families and clinicians by helping people move smoothly from referral to care, while ensuring health information is accurate, secure and treated with respect. When a referral is received, the team sets up patient records, schedules initial appointments when appropriate, and communicates clearly with patients and families about referral outcomes.

Health records are carefully managed, both paper and electronic, to ensure all information is complete and available to support care. The Electronic Medical Record (EMR) system is maintained to support efficient service delivery, including managing appointment types and system access.

Throughout all activities, strong privacy and confidentiality practices are followed to protect personal health information and CASA's confidential business information. This includes employee training, responding to questions about access to information, managing privacy concerns and ensuring information is handled responsibly and in accordance with applicable privacy legislation and organizational policies.

## Who delivers the service

The Privacy and Health Information team consists of a mix of administrative support personnel, coordinators, privacy advisors and the manager.

## Intake Services

- Assists families and external providers who wish to refer to CASA.
- Creates new patients in the EMR and supports the clinical teams with referral management and admission to programs.

## Health Records Clerks

- Manages the records lifecycle for patient records.
- Ensures patient health records are complete, accurate, and compliant by auditing charts, confirming required documentation is present.

## EMR Coordinators

- Provides frontline and behind-the-scenes operational support for the EMR, including creating, modifying and disabling user accounts and profiles, managing Netcare access, administering Ocean appointment reminders and delivering EMR help desk support to clinical employees.
- Supports clinical operations by training employees on EMR use and by configuring system functionality.

## Privacy Advisors

- Provides organization wide guidance on privacy-by-design, ensuring compliance with all applicable legislative and regulatory requirements.
- Manages privacy incidents and breaches, including conducting independent investigations, assessing risk and impact, recommending mitigation strategies, and overseeing implementation of corrective actions.
- Supports organizational accountability through proactive monitoring and education.

## Privacy and Health Information Manager

- Provides direction and oversight to ensure the accuracy, completeness, availability and security of patient information across its lifecycle.
- Ensures the EMR and related health information systems are governed as critical organizational assets that support safe, efficient and high-quality care.
- Liaises with the Office of the Privacy Commissioner and other organizations as necessary ensuring timely, transparent and compliant responses to regulatory inquiries and reporting obligations.

## How we connect across CASA

Privacy and Health Information connects across CASA through a myriad of touchpoints with employees at all levels of the organization from the administrative team right through to the senior leadership team. Through these touchpoints the service collaborates to support shared workflows from referral through discharge, releases of information, and the records management lifecycle.

## How we measure success

- Tracking of employees that have completed privacy training and annual refresher training within 30 days of notification.
- Number of clinical employees who have received EMR training within 30 days of hire.
- Number of information security incidents that exceeded harms threshold.
- Percentage of requests for information completed within legislated timelines.
- Time to process referrals and add patients to the waitlist for program review.

## Service Volume to Date

Metric	12 Month Totals
Employees that received privacy training	160
New EMR Users set up	180
Hours of EMR training delivered	450
Number of information requests received	155
Referrals received	3,115
Privacy incidents reported / exceeded harms threshold	22 / 0
Privacy inquiries from employees	69

## 2026-2027 Budget

### Expenses

Salaries	766,794
Benefits	153,359
<b>Total Salaries and Employee Benefits</b>	<b>920,153</b>
Program Materials & Supplies	200
Education, Conferences & Workshops	15,336
Team Building	1,100
Travel & Subsistence	3,500
Office Materials & Supplies	1,200
Software & Subscription	180,000
Other Services & Rentals	18,000

<b>Total Program Expenses</b>	<b>219,336</b>
<b>Total Expenses</b>	<b>1,139,489</b>

<b>Position Name</b>	<b>FTE</b>
Electronic Medical Records (EMR) Coordinator	3.00
Health Records Clerk	1.00
Intake Services	2.80
Manager, Privacy and Health Information	1.00
Privacy Advisor	2.00
Senior Health Records Clerk	1.00
<b>Grand Total</b>	<b>10.80</b>



# Program Management Office

## Who we help

The Program Management Office (PMO) is a business department that partners with CASA's leaders to enable successful delivery of key organizational projects and initiatives. We serve the:

- CEO office;
- Senior Leadership Team (SLT);
- Operational Leadership Team (OLT); and
- Project sponsors and conveners across CASA.

The PMO has two units: the Program Support Unit and the Capital Expansion Unit. The Program Support Unit provides project and change management services for program expansion and organizational initiatives. A dedicated Capital Expansion (CapEx) unit leads the construction project of four new buildings across Alberta.

## What happens in the department

We provide services such as project and change management, annual operational plan coordination, expansion support, interdependency collaboration and process standardization. These foundational services ensure consistency, efficiency and alignment across the organization.

The PMO supports leaders across CASA as they focus on clinical care and business operations, helping to guide processes, alignment, clarity and change readiness.

The PMO consists of professionals with years of experience managing complex projects and careholder relations. We are fortunate to have a curated multidisciplinary team with backgrounds in health care, construction, communications, information technology, education, philanthropy, Indigenous Relations and government relations, enabling strategic support for the key programs and services within CASA.

The PMO strengthens CASA's ability to deliver strategic initiatives by providing:

### 1. Project Management

Complying with the PMO's Project Management Framework, project managers engage subject matter experts and staff from across clinical program areas and business operations to guide project work from initiation through completion. The Program Management Office can also provide consultative or supporting resources while a team leads its own project. Our services include:

- Project management of CASA's annual operational plan deliverables;
- Expansion project management;
- Change management; and
- Interdependency collaboration.

The PMO Capital Expansion (CapEx) unit leads the planning, coordination and management of CASA's multi-site construction project, ensuring accountability, alignment, budget compliance, schedule and delivery from concept through construction and operational transition.

### 2. Organizational Change Management

Preparing and equipping people for change is critical to project success and to maintain momentum while reducing change fatigue, particularly as CASA expands its programs and services to reach more children, youth and families.

Our project and change managers apply a structured change management approach that provides support for individuals, direction for projects and efficiency for the organization overall.

We support sponsors, project leads and people leaders at all levels to confidently lead their teams through change by providing tools, guidance and communication strategies that build understanding, engagement, commitment and success across CASA.

We have a dedicated Organizational Change Management Lead, responsible for leading organizational change management practices in alignment with the PMO's Project Management Framework working closely with senior leadership to achieve high employee engagement and adoption of change initiatives.

### 3. Facilitation and Collaborative Support

Beyond our core functions, the Program Management Office offers à la carte services to meet unique or emerging organizational needs, including:

- Workshop facilitation;
- Strategic planning facilitation; and
- Neutral and trusted thought partnership.

### How we connect across CASA

- **Leadership Partnership:** We work directly with leaders to help scope, launch and support projects that advance CASA's strategic priorities.
- **Cross-Functional Collaboration:** Project managers coordinate interdisciplinary teams to ensure alignment, clarity and consistent execution.
- **Capital Expansion Collaboration:** We coordinate all partners, consultants, careholders and internal teams for CASA's multi-year capital expansion project.
- **Emerging Needs:** Leaders may request PMO support at any time during the year for emerging or evolving initiatives.

### How we measure success

The PMO is developing a dashboard and reporting model aligned with the Project Management Framework to track and report these metrics. Project and PMO performance indicators include:

- on-time delivery of project milestones;
- effective project risk identification, mitigation strategies and escalation;
- change readiness and adoption;
- lessons learned and continuous improvement integration; and
- capital expansion project delivery and outcomes.

## 2026-2027 PMO Department Budget

### Expenses

Salaries	736,640
Benefits	147,328
<b>Total Salaries and Employee Benefits</b>	<b>883,968</b>
Program Materials & Supplies	2,000
Education, Conferences & Workshops	23,301
Team Building	1,000
Travel & Subsistence	24,000
Office Materials & Supplies	1,000
Software & Subscription	1,000
Professional Consulting / Services	10,000
Memberships & Dues	3,000
<b>Total Program Expenses</b>	<b>65,301</b>
<b>Total Expenses</b>	<b>949,269</b>

<b>Position Name</b>	<b>FTE</b>
Organizational Change Management (OCM) Lead	1.00
Program Management Support Lead	1.00
Project Manager, Clinical Programs and Services	1.00
Project Manager, Operations	2.00
Manager, Program Management Office	1.00
<b>Grand Total</b>	<b>6.00</b>

<b>2026-2027 Capital Expansion Unit Budget</b>	
<b>Expenses</b>	
Salaries	428,426
Benefits	85,685
<b>Total Salaries and Employee Benefits</b>	<b>514,111</b>
Program Materials & Supplies	7,000
Travel & Subsistence	28,800
<b>Total Program Expenses</b>	<b>35,800</b>
<b>Total Expenses</b>	<b>549,911</b>

<b>Position Name</b>	<b>FTE</b>
Director, Program Management Office	1.00
Manager, Capital Expansion	1.00
Project Coordinator, Capital Expansion	2.00
<b>Grand Total</b>	<b>4.00</b>

# Volunteer Resources

## Who we serve

The Volunteer Resources department serves volunteers (external community members) and all clinical programs and business operations at CASA, while the 400+ volunteers serve CASA patients and families through childminding and staff through event support, research, toy cleaning and other initiatives.

## How we help

The Volunteer Resources department serves all registered volunteers and external community members looking to give their time to our organization. We are committed to enhancing, strengthening and complementing the patient, family and staff experience through the deployment of a diverse and skilled unpaid volunteer workforce to support a variety of clinical programs, services, administration tasks, philanthropic events and initiatives. Our goal is to help staff access Volunteer Resources supports in their roles and departments, reduce barriers to care for our families and provide our volunteers with a robust volunteer program in which they can participate in meaningful engagement opportunities and be well equipped to support the organization.

## What happens in the service

The Volunteer Resources team provides a wide variety of services for CASA, including:

- Consultation, strategy and volunteer needs assessment with CASA departments;
- Recruitment, onboarding and orientation support;
- Volunteer background screening;
- Volunteer scheduling and placement;
- Volunteer appreciation and stewardship;
- Volunteer reference letter and hour confirmation;
- Volunteer hour and impact contribution tracking;
- Ongoing training, performance and compliance management; and
- Legislation and best practice guidance in Volunteer Resources functions.

## Who delivers the service

This service is delivered by CASA Mental Health volunteers, who are community members bringing unique talents, skills and knowledge to complement and strengthen the quality of care and operational support provided by professional staff. Programs and departments must collaborate with Volunteer Resources and volunteers to ensure CASA offers a comprehensive volunteer program with meaningful experiences and opportunities to benefit all parties.

There are two streams of volunteering at CASA Mental Health:

**Support stream:** every CASA volunteer begins in the support stream. These volunteers provide meaningful assistance with administrative tasks related to programs, research, donor stewardship, marketing and fundraising events. To volunteer in the support stream, the individual must complete: an application; a volunteer placement interview and orientation, and the required documents and training.

**Clinical stream:** these volunteers assist CASA's clinical programs, work directly with CASA patients and families, and must be comfortable supervising children. Clinical stream volunteers must be 18 years of age or older, actively volunteer in the support stream and complete the following (in addition to the support stream requirements): Vulnerable Sector Police Information check and a Child Intervention Record Check.

CASA's board of directors and Youth and Family Advisory Council members are considered registered volunteers who are accountable to other functions within the organization.

Volunteer Resources is staffed by individuals with post-secondary education and additional training and certifications in volunteer management and engagement.

## How we connect across CASA

Volunteer Resources connects across the organization and community to promote and advance volunteerism, contribute to collective action and ways to give, and foster CASA Mental Health as a charity of choice for volunteers. This includes supervising the coordination of meaningful volunteer opportunities that augment CASA programs, services and events. Volunteer Resources will collaborate across many staff teams to coordinate volunteers as we strive to assist in the delivery of essential clinical programs and services along with successful fundraising events in support of children, youth and family mental health. Specifically, Volunteer Resources connects in the following ways:

- Liaise with CASA staff and departments to understand/assess the volunteer needs of the organization and advocate for the CASA volunteer.
- Consult with CASA clinical programs to develop and maintain unique, value-added opportunities for volunteers to enhance CASA patient's experience and reducing barriers to participation in clinical programs and services (e.g. childminding, support group setup and assistance, workshops led by volunteers).
- Consult with CASA administrative and SLT staff to develop unique, value-added opportunities for volunteers to enhance CASA's programs and services and assist in reaching leadership goals.
- Consult with CASA Business Operations and Philanthropy teams to support and provide the needed volunteer resources to support the many fundraising events and initiatives to assist in reaching CASA philanthropic goals.

### CASA staff who have identified a potential volunteer opportunity may:

- Complete the CASA staff volunteer request form on CASA Connect.
- Based on the parameters of the request, Volunteer Resources will recruit, confirm and schedule volunteers for the opportunity.
- Volunteer Resources will report back to the individual from the program or department that requested the opportunity.
- To ensure the most positive and meaningful volunteer experience, the requesting programs and departments are responsible for aspects of the ongoing management of CASA volunteers for the duration of the opportunity.

## How we measure success

Volunteer Resources measures success through established metrics listed in the table below. For a glossary of terms, please refer to the Volunteer Resources business glossary document or visit the Volunteer Resources Data Domain on CASA Connect: <https://intranet.casaservices.org/content/19633/domain-volunteer-data>.

### Target service volume

Metric	2026-27	2027-28	2028-29
<b>Number of opportunities</b>	Goal: 125	Goal: 150	Goal: 150
<b>Shift fill (engagement) rate</b>	Goal: 80 per cent (550/688)	Goal: 80 per cent	Goal: 85 per cent
<b>Number of engagements with volunteers</b>	Goal: 550	Goal: 650	Goal: 750
<b>Number of volunteer hours (includes board and YFAC)</b>	Goal: 5,000	Goal: 5,500	Goal: 6,000
<b>Barriers to care reduced</b>	Goal: 70	Goal: 100	Goal: 120
<b>Number of volunteers</b>	Goal: 550	Goal: 600	Goal: 650

## 2026-2027 Budget

### Expenses

Salaries	219,246
Benefits	43,849
<b>Total Salaries and Employee Benefits</b>	<b>263,096</b>
Program Materials & Supplies	15,000
YFAC Events	3,000
Education, Conferences & Workshops	4,385
Team Building	300
Travel & Subsistence	1,000
Software & Subscription	4,500
Media / Advertising	500
Other Services & Rentals	1,000
Memberships & Dues	7,500
<b>Total Program Expenses</b>	<b>37,185</b>
<b>Total Expenses</b>	<b>300,280</b>

### Position Name

### FTE

Manager, Volunteer Resources	1.00
Volunteer Resources Coordinator	1.00
Youth and Family Advisory Liaison	1.00
<b>Grand Total</b>	<b>3.00</b>



# Youth and Family Advisory Council

## Who we serve

CASA's Youth and Family Advisory Council (YFAC) serves as the voice of patients, families and youth who have navigated the mental health system in CASA and elsewhere in Alberta. YFAC connects with CASA's senior leadership, Board of Directors and other staff to share their stories and experiences, and as needs for patient and family member feedback are identified.

## How we help

YFAC informs, guides and advises CASA Mental Health on creating an organization with an approach to care, policies, procedures and practices that puts those we serve at the centre of our decisions and service model. The council also acts as a resource sharing their knowledge, skills and lived experiences with CASA. The council works to reduce stigma against children and adolescents with mental illness and their families through community outreach and increasing public awareness of the council's role and CASA's services.

## What happens in the service

- **Advising**
  - Working collaboratively with the Senior Leadership Team (SLT) in developing and providing feedback on the organization's strategic plan, policies and procedures.
  - Advising on policies, procedures and practices.
  - Providing members to sit on various CASA committees.
  - Participating in and providing feedback on events and strategies, including those related to strategic planning, advocacy and fundraising.
- **Advocating**
  - Working in collaboration with Youth and Family Voices Network members on mental health advocacy initiatives.
  - Advocating for child, adolescent and family mental health services.
  - Raising community awareness and working to reduce stigma of the current and evolving mental health challenges facing children and youth.
  - Identifying, preparing and facilitating family/patient stories.
- **Projects**
  - Unseen Zine, a youth produced mental health mini magazine.
  - Events such as Family Fest and other event collaboration.
  - Others as identified by council.

## Who delivers the services

The Youth and Family Advisory Council will have a membership of 16 people:

- Up to seven youth between the ages of 16 and 24 with lived experience in navigating the child and adolescent mental health care system (of whom four must have received or are receiving CASA services), including Youth Co-Chair.
- Up to seven family members/caregivers of current or former CASA patients, including Family Co-Chair.
- The Youth and Family Advisory Liaison (Liaison Co-Chair).
- CASA's Director, Corporate and Community Relations, as the Senior Leadership Team representative.

Network membership consists of youth who are between the ages of 12 and 24, passionate about mental health advocacy and reside in Alberta, as well as adults who are caregivers or family members of children or youth with mental health challenges and reside in Alberta.

All Youth and Family Advisory Council members are members of the Youth and Family Voices Network.

## How we connect across CASA

- CASA staff can request time at a monthly YFAC meeting via a request form on CASA Connect or by contacting the Youth and Family Advisory Liaison.
- Council members and news can be found in the Circle of Care Newsletter and on social media (@Casa.Voices).
- All patients are given materials with information about Youth and Family Voices opportunities at discharge. Youth and Family Voices also may deliver presentations to each cohort of teens and/or parents.
- YFAC members attend an annual Catchball meeting to inform operational planning, as well as capital expansion engagement sessions to inform the new CASA Houses.
- YFAC members often provide zine/art workshops to patients at CASA House.

## How we measure success

Success can be measured in the number of advisory items brought to council meetings annually (five in 2024-25), hours contributed (~600 in 2024-25) and opportunities for members to engage with CASA committees and member recruitment and retention.

## Target service volume (YFAC membership)

Metric	2026-27	2027-28	2028-29
Council members	16	16	16
Network members	10	20	30

Position Name	FTE
Youth and Family Advisory Liaison	1.00
<b>Grand Total</b>	<b>1</b>

Budget and FTE are included with Volunteer Resources on page 125.

# Organization Chart

## Board of Directors

Katie Hayes, Chair  
 Krystal Gray, Vice Chair  
 Megan Picard, Treasurer  
 Bryan Mwaka, Secretary  
 Lara Oberg-Stenson (Past Chair)  
 Glen Anderson  
 Conny Avila

Lindsay Bilkoski  
 Melanie Ducholke  
 Christine Kennard  
 Barry McNabb  
 Jay Williamson  
 Bonita Young

## Chief Executive Officer

Bonnie Blakley

## Senior Operating Officers (acting)

Amanda LaFrance, Dena Pedersen

## Executive Assistant

Melissa Mandzuik

### Medical Director Dr. Andrea Yu

- Medical Affairs

### Director, Clinical - CASA Classrooms Lori Roe

### Director, Clinical - CASA House and Day Programs Tanya Kendall

- CASA House
- Adolescent Day Program
- Children's Day Program
- Preschool Day Program

### Director, Clinical - Outpatient Programs Sharon Ling (acting)

- Core
- Family Therapy
- Trauma
- Psychiatric and Medical Clinics

### Director, Clinical - Diversity and Indigenous Initiatives Carrie Avveduti

- Inclusivity, Diversity, Equity and Accessibility
- Indigenous Wellness Support Services
- FASTRACS
- First Nations, Métis and Inuit Mental Health Services
- Comprehensive School-Based Mental Health Program

### Director, Clinical - Interprofessional Practice Dr. Mike Sornberger

- Assessment and Consultation
- Clinical Administration
- Interprofessional Practice
- Professional Development and Education
- Triage, Navigation and Transition

### Director, Philanthropy Nadine Samyca

### Director - Finance Jeremy Prystay

- Finance
- Information Technology (acting)
- Privacy and Health Information (acting)

### Director, Program Management Office Paula Colvin

- Capital Expansion
- Program Management Office

### Director, Business Operations Tina Fedyna (acting)

- Business Intelligence and Evaluation
- Facilities
- Occupational Health and Safety
- Quality and Risk

### Director, Corporate and Community Relations Darby Semeniuk

- Communications
- Marketing
- Volunteer Resources
- Youth and Family Advisory Council
- People and Culture (acting)

