

## CWLC National Mental Health Scan

### Introduction

Child and youth mental health is an area of growing concern and priority in Canada. There is a lack of information about the systems, programs and policies across the country. CWLC (Child Welfare League of Canada) undertook its first national scan to improve what is known about child and youth mental health. This scan was part of a larger effort on the part of CWLC, who co-hosted, along with the Public Health Agency of Canada, Ontario's Provincial Centre of Excellence for Children and Youth Mental Health at CHEO, the Canadian Association of Paediatric Health Centres and the Alberta Centre for Child, Family and Community Research, the *National Invitational Symposium on Child and Youth Mental Health* in September 2007.

### Methodology

The questionnaire was sent out to a variety of key stakeholders in child and youth mental health across Canada. All 115 CWLC members received the questionnaire. CWLC membership is comprised of approximately 1/3 government departments, 2/3 service delivery agencies and 1/3 associations (provincial organizations, research organizations, etc.). In addition, the questionnaire was distributed to provincial mental health associations such as Children's Mental Health Ontario and the Alberta Mental Health Board for their distribution to member agencies. The Federal/Provincial/Territorial Advisory Network on Mental Health distributed the questionnaire to their network of government departments and agencies as well. Finally, the partner organizations who participated in the *National Invitational Symposium on Child and Youth Mental Health* also received the questionnaire. Because the distribution of the questionnaires went through a variety of networks, it is difficult to determine an exact number of recipients. However, it is safe to estimate that there were at least 150 questionnaire recipients, divided amongst government departments, service delivery agencies and other types of associations.

In total, 38 completed questionnaires were returned from across the country. All jurisdictions had respondents except for Prince Edward Island and Newfoundland and Labrador. The questionnaire received from Nova Scotia was not completed, so they are missing from the data analysis in all questions in Section C. For those jurisdictions where only there is one respondent, they are most likely a government department. The provinces with a larger response rate saw a greater mix of both government departments and service delivery agencies. There was an overall lack of responses from those who would fall into the "associations" category. The reasons for this are unclear, but could point to the fact that these associations did not feel they were the most appropriate group to respond to this scan, and left the responses to front-line agencies and government departments. Question C6 gives an overview of which sector respondents represented by province.

There are strengths and weaknesses to the scan as it was structured and disseminated. Because of the national scope, there is a flavour of the variety of policies and programs occurring in almost all corners of Canada. Key stakeholders were able to voice their vision and concerns for child and youth mental health in their jurisdiction and give important insight into what this looks like from the frontlines to government policy levels.

Because the questionnaire was not completed by all jurisdictions, there is some key information missing that limits our understanding of child and youth mental health at a truly national level. Further, because the respondents were often only responding from their perspective, the data cannot always be accurately applied across the jurisdiction. This also impacts on the “whole picture” that may not be presented as key informants did not complete the survey for a variety of reasons and may be holding key pieces of the child and youth mental health puzzle.

As respondents were from a variety of disciplines and organizations, some respondents did not always directly address children’s mental health, but other issues related to the children and families being served by a particular respondent. This is not to negate the value of this information and it does contribute to an understanding of how child and youth mental health is integrated into other service delivery areas.

While understanding the limitations of the scan, it does still provide far more information about what is happening in child and youth mental health nationally than has previously been known. From here we can begin to understand trends and learn from the strengths presented in each jurisdiction. There is something to be learned from each other in how we strive to best serve children and youth and their families in the area of child and youth mental health.

The following is each question from the questionnaire with the responses compiled by province/territory. An analysis and commentary on each chart is included to assist with understanding the richness of the information provided. It should be noted that the commentary is based on the information provided by the respondents, but this information has not been independently verified. We relied on the expertise and opinions of those closest to the child and youth mental health system to tell us what they know and experience.

**B1 - Which ministries serve children and/or youth with mental health needs in your jurisdiction?**

	Children's Ministry	Health	Justice	Education	Human Resources / Employment	Aboriginal Affairs	Family / Community Services	Other
British Columbia	3	3	0	0	0	0	0	0
Alberta	7	7	7	6	2	4	0	1
Saskatchewan	0	3	2	2	0	0	3	0
Manitoba	0	2	1	2	0	0	1	1
Ontario	15	8	1	2	0	0	3	0
Quebec	0	3	0	0	0	0	0	0
Nova Scotia	0	1	0	0	0	0	0	0
New Brunswick	0	1	1	1	0	0	1	0
Yukon	0	1	0	0	0	0	0	0
Northwest Territories	0	1	0	0	0	0	0	0
Nunavut	0	1	0	0	0	0	0	0

Each jurisdiction has a good understanding of which government departments are responsible for the delivery of child and youth mental health services. However, the more respondents per jurisdiction, the more likely other government departments - beyond the ones all respondents listed - would be identified.

In general, health departments were most often the provider of these services. However, those provinces who have a department specifically related to children tended to have overlap between the two departments. The three territories combine health and social services into one ministry so the responsibilities tend to be centralized.

## B2 - For each ministry identified, who is responsible for service delivery?

	Ministry Directly	Regional Authority	Private Providers	Social Service/ Transfer Agency	NGOs	Other
British Columbia	3	2	1	0	1	0
Alberta	1	5	2	0	2	4
Saskatchewan	1	3	1	0	2	1
Manitoba	0	2	1	2	1	0
Ontario	3	2	3	15	1	0
Quebec	0	1	0	1	1	1
Nova Scotia	0	1	0	0	0	0
New Brunswick	1	1	0	1	1	0
Yukon	1	1	1	0	1	0
Northwest Territories	1	1	0	0	1	0
Nunavut	0	0	0	1	0	0

Across provinces and territories, there is a wide variety of public, private and community service delivery models. A few of the jurisdictions with multiple respondents were able to agree on one group responsible (British Columbia, Saskatchewan and Ontario), but there is still considerable variation about all relevant groups responsible for service delivery. This indicates that it is not very clear in most jurisdictions who take primary responsibility for delivery of child and youth mental health services. This range of service options does provide for choice, but may also create challenges with respect to access, availability, informed choice, collaboration, planning and gaps.

Because several provinces and territories only have one respondent, it is difficult to determine if there is a consensus in that jurisdiction regarding service delivery responsibility, or if more respondents would lead to the same pattern of variability displayed by other provinces who responded in larger numbers.

The category of "other" listed a variety of organizations, many of whom could be classified under other existing categories. The organizational structure of governments and their service delivery models appears to lead to some confusion and contributed to some respondents using the "other" category.

**B3 - Does your jurisdiction have a formal policy or plan for children's mental health services?**

	Yes	No
British Columbia	3	0
Alberta	6	0
Saskatchewan	3	0
Manitoba	0	2
Ontario	10	4
Quebec	2	1
Nova Scotia	1	0
New Brunswick	0	1
Yukon	0	1
Northwest Territories	1	0
Nunavut	0	1

Overall there tends to be a good knowledge of the state of a formal children's mental health plan in each jurisdiction. Many provinces and territories have a formal plan, while others are in progress. Manitoba indicated they are in the process of developing a plan, as is Northwest Territories. Northwest Territories does currently address children's mental health in a number of other policies related to children and youth. Nova Scotia indicated there is a formal policy or plan in that province, however, from the response given on the survey it is unclear if it is a formal plan or if it is just an understanding of what department has authority to deliver services.

British Columbia, Alberta and Saskatchewan had consensus amongst all their respondents about formal policies and/or plans in their jurisdiction.

New Brunswick, Yukon and Nunavut all indicated that there is currently no policy or plan for child and youth mental health in their jurisdiction.

Ontario presents a unique situation because of the large number of respondents. While it appears as though 2/3 of the respondents indicated that a formal plan or policy exists, in reality, only 1/3 of respondents identified the provincial plan for child and youth mental health. The other 1/3 made reference to local plans or initiatives related to child and youth mental health without mentioning the larger policy at the provincial level. This means that 2/3 of respondents in Ontario did not appear to be familiar with the provincial plan, or consider it the most important policy, even though almost all respondents were child and youth mental health service providers.

**B4 - Do you have policy mechanisms that link child and youth mental health related policies across ministries?**

	Yes	No
British Columbia	3	0
Alberta	5	2
Saskatchewan	1	2
Manitoba	1	1
Ontario	1	12
Quebec	1	2
Nova Scotia	1	0
New Brunswick	0	1
Yukon	0	1
Northwest Territories	1	0
Nunavut	0	1

British Columbia and Alberta, along with the single respondents from Nova Scotia and Northwest Territories all have policy mechanisms in their jurisdictions.

The respondents in Saskatchewan were split in their responses; however, the added commentary on the surveys indicated that they did feel there was some policy overlap and coordination, but not all of it is formal or always available.

In Quebec, the government department who responded felt that there are mechanisms in place; however, the two service delivery agencies who responded did not agree.

Northwest Territories, while believing there are policy mechanisms in place to link across departments, was clear to indicate that the policies that currently exist are not child and youth mental health specific but address a variety of children's issues, which includes mental health.

## B5 - Does your jurisdiction have access to data linked across ministries?

	Yes	No
British Columbia	2	1
Alberta	2	5
Saskatchewan	0	3
Manitoba	0	2
Ontario	0	14
Quebec	0	3
Nova Scotia	1	0
New Brunswick	0	1
Yukon	0	1
Northwest Territories	0	1
Nunavut	0	1

Almost universally across all jurisdictions, access to data linked across ministries does not exist. Both British Columbia and Nova Scotia indicated that when this access does exist, it is limited. The exception to this is Alberta. While the majority of respondents indicated that this access currently does not exist, they all spoke to an initiative underway, the *Child and Youth Data Laboratory*, which will lead to this access in the future.

**B6 - Does your jurisdiction have data linked across sectors at the service delivery level?**

	Yes	No
British Columbia	3	0
Alberta	2	5
Saskatchewan	0	3
Manitoba	0	2
Ontario	4	9
Quebec	1	2
Nova Scotia	1	0
New Brunswick	0	1
Yukon	0	1
Northwest Territories	1	0
Nunavut	0	1

Access to data across sectors varies considerably across the country. British Columbia, Nova Scotia and Northwest Territories all indicated that this exists in their jurisdiction. Saskatchewan, Manitoba, New Brunswick, Yukon and Nunavut all indicate that there are no data linkages across sectors. Alberta, Ontario and Quebec have a mix of responses indicating a level of confusion in these provinces. The Quebec government respondent indicated that there is data linked across sectors at the service delivery level, but the service providers themselves did not indicate this to be the case.

**B7 - Do you have standard screening mechanisms in place for early identification of possible mental health needs?**

	Yes (if so, at what age?)	No
British Columbia	1	2
Alberta	3	4
Saskatchewan	0	3
Manitoba	1	1
Ontario	7	8
Quebec	2	1
Nova Scotia	1	0
New Brunswick	0	1
Yukon	0	1
Northwest Territories	1	1
Nunavut	0	1

In the provinces that had multiple respondents, there is very little consensus about these standard screening mechanisms, indicating that while this service is done, it may not be consistently available across each province/territory.

Alberta currently has a pilot project in place related to early identification, and this is what all respondents who indicated “yes” referred to.

The Nova Scotia respondent indicated that there are standards for early identification, which may not be the same as standardized screening tools.

Yukon indicated that while there are not standard screening mechanisms across different departments, they do employ an early identification tool within mental health services.

Northwest Territories answered both yes and no to this question. This is because there is screening in place that can detect some mental health issues, and some screening is specifically for mental health issues, but there is no mental health specific screening tool being used consistently across the territory.

While the question specifically asked for the age at which the early identification screening mechanisms applied, this was not answered consistently, so no accurate data could be gathered.

## C1 - What type of child and youth mental health services do you provide?

(see Excel spreadsheet for chart)

Each province and territory provides a range of services. Rehabilitation, respite, support groups and telephone support services were areas that had fewer respondents providing services. The information contained in this chart may not accurately reflect the availability of all services in each jurisdiction as it was designed to understand the services provided by the respondents, not a holistic understanding of all the services available in the jurisdiction.

## C2 - Is a health card required to access these services?

	Yes	No
British Columbia	0	3
Alberta	3	3
Saskatchewan	2	1
Manitoba	1	1
Ontario	0	14
Quebec	0	2
New Brunswick	1	0
Yukon	0	1
Northwest Territories	0	1
Nunavut	1	0

The majority of jurisdictions do not require a health card to access services. It is anticipated from the results that while a health card does not always need to be shown, that the costs associated with the services provided will be covered by a provincial or territorial health insurance plan. For those respondents who do require a health card for services, they are not offering services unique from those who do not require a card. Thus, it seems as though the information gathered from this question is not particularly telling of any trend.

### C3 - Is there a cost associated with your services?

	None	Some	All
British Columbia	3	0	0
Alberta	4	1	0
Saskatchewan	2	0	1
Manitoba	1	1	0
Ontario	13	1	0
Quebec	1	1	0
New Brunswick	1	0	0
Yukon	1	0	0
Northwest Territories	1	0	0
Nunavut	1	0	0

The vast majority of respondents indicated that they do not charge for services. This means the majority of child and youth mental health services available across the country are available at no cost to caregivers. However, those who indicated that a fee for service arrangement was in place were almost all providers of residential services where the fees were not the responsibility of the client.

#### C4 - Are you a Single Point of Access?

	Yes	No
British Columbia	2	0
Alberta	1	4
Saskatchewan	1	2
Manitoba	0	2
Ontario	7	7
Quebec	1	1
New Brunswick	1	0
Yukon	0	1
Northwest Territories	0	1
Nunavut	0	1

Across jurisdictions there is a fairly even split of respondents who are a single point of access and those who are not. This reflects the variety of respondents who may be front-line service providers, government departments and/or agencies or other stakeholders in child and youth mental health.

While Northwest Territories indicated that it is not a single point of access, it does have teams at the community level that have led to more coordinated access.

What is unclear from the respondents is if they are a single point of access how they coordinate with other service providers and vice versa.

## C5 - Do you have a standardized screening procedure?

	Yes	No
British Columbia	2	1
Alberta	0	5
Saskatchewan	2	1
Manitoba	1	0
Ontario	12	2
Quebec	2	0
New Brunswick	1	0
Yukon	1	0
Northwest Territories	0	1
Nunavut	0	1

Each jurisdiction appears to be fairly consistent on the use of standardized screening procedures. Most respondents use some form of standardized screening but from the variations within jurisdictions, it does not appear to be mandatory. Alberta, Northwest Territories and Nunavut all indicated they do not use these procedures while all other jurisdictions have at least one respondent who does. Yukon did indicate that while its Mental Health Services does use a standardized screening procedure, this is not the case in other units of the Department of Health and Social Services.

## C6 - What kind of organization do you represent?

	Community-based Services	Government	Health Centre	Hospital	Public Education	Other
British Columbia	1	3	0	1	0	1
Alberta	2	2	0	0	0	3
Saskatchewan	1	2	0	0	0	0
Manitoba	0	2	0	0	0	0
Ontario	13	0	0	0	0	2
Quebec	0	1	0	0	0	2
New Brunswick	1	1	1	1	0	0
Yukon	0	1	0	0	0	0
Northwest Territories	1	1	1	1	0	1
Nunavut	0	1	0	0	0	0

Respondents interpreted this question in a variety of ways, thus indicating more responses per jurisdiction than actual respondents. Some government departments included all the relevant types of organizations funded through their department or who provided services to their clients. The majority of jurisdictions with only one respondent were from government organizations. This does not give a good indication of what service delivery looks like at the grassroots level or account for the views of those who are directly providing services.

With the exception of Ontario, the bulk of respondents were from government in some capacity, most often departments with a mandate to provide child and youth mental health services, or serve children, youth and/or families that may require child and youth mental health services.

As with question B2, the "other" category appears to be mostly organizations that would fall under the existing categories. Organizational confusion and jurisdictional definitions led the use of the "other" category. This category also includes some provincial organizations that are involved in the child and youth mental health arena but cannot be categorized under the existing options.

## C7 - What types of assessments does your organization conduct?

(see Excel spreadsheet for chart)

Overall, there appears to be limited access to neurological and youth justice assessments.

The assessments available in the three territories seem to be limited. It is unclear whether other organizations exist in these jurisdictions to conduct the assessments or if there is truly a lack of availability. Northwest Territories indicated that while the assessments listed are available, there is limited capacity to carry them out in a timely manner.

One Manitoba respondent who indicated that they conduct assessments noted that the assessment types listed are carried out through agencies and organizations funded by the government, as the respondent does not directly do them.

Much like question C1, the information contained in this chart may not accurately reflect the availability of all assessments that can be conducted in each jurisdiction as it was designed to understand the assessments provided by the respondents, not a complete understanding of all the assessments potentially available in the jurisdiction.

## C8 - In what settings do you provide services?

(see Excel spreadsheet for chart)

The majority of jurisdictions offer services in a variety of settings that will meet the needs of clients. Services do not appear to be offered in school-based settings by many respondents, however, as none of the respondents were from the public education system. It is possible that these services are offered by others who were not respondents to this survey.

Of note is Yukon and Nunavut's offering of services only in the office/clinic setting. Given the remoteness of much of the populations in these territories, it is unclear how many offices/clinics are available and if clients across the jurisdiction have ready access to their services.

**C9 - Does your organization engage in any strategies for breaking down service barriers due to geographic location?**

(see Excel spreadsheet for chart)

Some respondents in each jurisdiction (with the exception of Yukon and Nunavut mentioned below) take efforts to break down services barriers as a result of geographic location. The “other” category provided insight into a variety of different strategies across the country. Manitoba noted that it has mobile crisis units in rural and remote areas, as well as psychiatrists who travel to provide consultations. Tele-mental health is in place in both Manitoba and Northwest Territories. Northwest Territories also has fly-in counsellors to communities where there is not adequate staffing. It should be noted that even those jurisdictions making efforts to break down geographic barriers are not serving all communities.

While both Ontario and Quebec indicated that they employ a variety of means to break down service barriers, none of the respondents are from geographically isolated areas, thus, they may not be facing the same sorts of barriers that confront remote and isolated communities.

Further to the issues raised in question C8, neither Yukon nor Nunavut engages in strategies for breaking down barriers due to geographic location. This is in contrast to other jurisdictions with much less of its population in remote areas yet working to break down barriers in a variety of ways.

**C10 - In your opinion, are your wait times a problem for your clients?**

	Yes	No	Unsure
British Columbia	1	1	0
Alberta	3	0	3
Saskatchewan	1	1	1
Manitoba	2	1	0
Ontario	11	2	1
Quebec	1	1	0
New Brunswick	1	0	0
Yukon	0	0	1
Northwest Territories	1	0	0
Nunavut	1	0	0

The majority of respondents indicated that their clients are being adversely affected by wait times. This is universal across jurisdictions. While Yukon responded “unsure” to this question, the respondent did indicate that wait times may be a problem for some clients.

For those respondents who did not think wait times were a problem for their clients, two trends appeared. Those respondents tended to be either government departments or child welfare service providers. Child welfare service providers often answered the question in relation to the wait times for child welfare services, which have mandatory response times, instead of the wait times these clients experience for mental health services.

**C11 - Please estimate, on average, how long clients can expect to wait:**

	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec	New Brunswick	Yukon	NWT	Nunavut
From first call to first face-to-face contact	2 weeks to 6 months	2 weeks to 1 year	2 weeks to 8 months	immediate to 3 months	24 hours to 4 months	1 - 2 weeks	depends on degree of priority. In urgent cases the wait time is decreased significantly	1-2 days	varies depending on staff and program availability	24 hours
From first face-to-face contact until intake		1 to 6 weeks		immediate to 3 months	1 week to 2 months			2 weeks		24 hours
From intake to assessment		3 weeks to 6 weeks		immediate to 3 months	1 week to 12 months			2 months		varies depending on what is available in the community

The structure of this question did not easily capture the variety of different service delivery structures across the country. Therefore, the wait time breakdown as outlined in this chart was not easy to categorize. Across the country it was noted by respondents that the wait times depended on the type of service required, and some services had significantly longer wait times than others. Many indicated that service delivery was prioritized based on urgency and that would decrease the wait.

As can be noted from the charts, wait times vary significantly within each jurisdiction and across them. For the most part, clients are usually waiting at least a couple of months to receive services, and significantly more if they require specialized programs.

Only one respondent from Quebec answered this question. This may impact on the accuracy of the wait times as listed, in part because the one respondent is a service deliver agency in an urban area. This does not take into consideration the wait time experienced by clients in other urban and rural areas of the province.

The wait times in the three Territories depend highly on the availability of resources - both human and community - to meet the needs of clients. Given the limited availability of resources and locations for service delivery as previously discussed in Nunavut (office/clinics), the wait times as listed require further information to understand the speed with which it appears clients can be seen initially.

**C12 - Do you provide children/youth and/or parents/caregivers with any supports while they are waiting for treatment?**

	Yes	No	Unsure
British Columbia	0	2	0
Alberta	3	2	0
Saskatchewan	2	1	0
Manitoba	1	1	0
Ontario	13	1	0
Quebec	1	1	0
New Brunswick	1	0	0
Yukon	0	0	1
Northwest Territories	1	0	0
Nunavut	1	0	0

The availability of supports to children and youth and their families is not consistent across the country. A number of jurisdictions noted that supports vary by region or are not consistently available. Because several respondents are not direct service providers, they were inclined to either not answer this question or select “no”. Thus, some of the “no” responses are organizations not mandated to do this kind of work.

### **C13 - If you offer supports, what are they?**

**British Columbia** - none of the respondents offer supports

**Alberta** - walk-in services, crisis lines, hospital emergency department, other community resources, print resources, primary care physician, faith-based supports, wait list management, referrals, casework supports

**Saskatchewan** - telephone support, psycho-educational support groups, community organizations, family physician, hospital emergency department, healthline mental health and addictions specialists

**Manitoba** - home-based supports for children with developmental and/or physical disabilities, staffing grants, supports offered by community organizations and funded by government

**Ontario** - print materials, wait list management, telephone outreach, parenting groups, family support, educational workshops, crisis management, intensive family social work

**Quebec** - emergency/crisis intervention

**New Brunswick** - print resources, some regions have groups, clients can call to update situation and update priority

**Yukon** - telephone support, referral to other resources

**Northwest Territories** - Primary Community Care team and adjunct caregivers provide interim support

**Nunavut** - child welfare, respite care, residential care

The supports offered to clients are not just supports available by the service delivery agency, but other community resources to assist the child or youth and his/her family. Hospital emergency services/crisis intervention are suggested supports in a number of jurisdictions. Referrals to other community resources is commonplace as well. Support groups and the use of print materials, either produced by the respondents or another resource, are often cited. A number of jurisdictions also have some sort of telephone support in place, either offered directly by the agency or larger scale (ie: provincial telehealth service).

Wait list management in some form is often available, to help prioritize clients. Nunavut listed the involvement of child welfare resources as the only known form of support.

**C14 - If you offer supports, at what point in the waiting period are they offered?**

**British Columbia** - respondents don't provide supports

**Alberta** - ranging from initial contact, throughout waiting period, and in some instances beyond the commencement of mental health services

**Saskatchewan** - as needed and determined by case plan

**Manitoba** - varies, but often offered immediately

**Ontario** - almost all respondents indicated supports available from intake onwards

**Quebec** - during wait time for assessment and beginning of services

**New Brunswick** - all along, as needed

**Yukon** - between intake and assessment

**Northwest Territories** - varies depending on severity of client need and available resources

**Nunavut** - immediately

For those agencies that offer supports, there is a general pattern of most offering these supports as soon as possible, or when they are identified as needed. Of particular note is one respondent in Alberta who indicated that not only do they offer supports prior to commencement of services, they may continue to offer supports to the family during treatment. In contrast, the Yukon respondent only has supports between intake and assessment, although they indicated a two-week waiting time to reach intake.

**C15 - Does your organization have formal partnerships with other agencies for service provision, training, research or education?**

	Yes (list)	No
British Columbia	3	0
Alberta	7	0
Saskatchewan	3	0
Manitoba	1	1
Ontario	14	0
Quebec	3	0
New Brunswick	1	0
Yukon	1	0
Northwest Territories	1	0
Nunavut	0	1

Almost universally the respondents had a variety of partnerships in across service provision, training, research and education, depending on the mandate of the respondents. These partnerships are most often at the community or provincial/territorial level. Some respondents indicated that partnerships are not always formal, this is particularly the case in Yukon around Autism Spectrum disorders. The respondent from Nunavut indicated that there are no partnerships in that territory related to child and youth mental health.

Although it was requested in the original question, because of the large list of partnerships from each respondent, it was decided to not list them.

**C16 - Do you presently have access to research expertise or resources at a nearby university?**

	Yes	No
British Columbia	3	0
Alberta	7	0
Saskatchewan	3	0
Manitoba	1	1
Ontario	8	6
Quebec	3	0
New Brunswick	1	0
Yukon	0	1
Northwest Territories	0	1
Nunavut	0	1

Access to relevant and up-to-date research is the foundation of strong policy and practice in child and youth mental health, yet, several jurisdictions indicated that they do not have access to such information or expertise. Government respondents in Manitoba, Yukon, Northwest Territories and Nunavut all indicated they do not have access, a concern since the majority of these respondents have considerable policy and program responsibilities in the area of child and youth mental health. The Northwest Territories respondent did indicate that there are informal research connections with a university, but there is currently no formal agreement.

In Ontario, almost half of respondents did not have access to research expertise. Many of these organizations have post-secondary education institutions (college, university or both) within their communities.

There is a strong link to research expertise in Western Canada, and in Quebec and New Brunswick.

### C17 - Does your organization have an active research program?

	Yes	No
British Columbia	3	0
Alberta	5	1
Saskatchewan	3	0
Manitoba	0	2
Ontario	6	9
Quebec	3	0
New Brunswick	0	1
Yukon	0	1
Northwest Territories	0	1
Nunavut	0	1

For the most part, those respondents who indicated they have access to research expertise are also partaking in an active research program in their home organization, be it a government department or service delivery agency. Of note is the fact that both Manitoba and New Brunswick do not have an active research program, although the same respondents indicated that they have access to research expertise.

As with the commentary in question C16, many jurisdictions do not have active research programs at the government level. This can have implications for the development of policies as well as practical implications in expectations for service delivery.

In Ontario, where the majority of respondents indicated that they do not have an active research program, two respondents who answered “no” indicated that they do participate in research, but not in a lead role. It is possible that other respondents who indicated “no” may also be involved in research but because they are not the leaders on the project, they do not consider themselves engaged in a research program, just participants in another’s program.

C18 - In your opinion, do you have any exemplary programs that you would like to see duplicated or replicated in other jurisdictions?

### **British Columbia**

*FRIEND*: anxiety prevention program targeted at all grade 4/5 students.

*Connect Parent Group*: (10 week psycho-education model).

*Bifrost*: (3 month intensive multi-systemic youth/family intervention); Response Care Plan (comprehensive assessment and care/treatment plan development with consultative and respite support to 18).

### **Alberta**

*Day Treatment Learning Program*: cross-ministry mental health treatment program with an on-site school program. It is designed for students with significant mental health difficulties requiring intensive family systems centred treatment and specialized educational settings. It is not restricted to students of a specific school board. This concept could be adapted to service the substance abusing population.

*Emotional Behavioural Education*: one staff dedicated to the provision of education regarding emotional and behavioural concerns. Education is provided across Ministries, to NGOs, parents and alternative caregivers.

*Exceptional Needs/Foothills Hospital Partnership*: program that moves kids out of hospital and back home.

*Habitat Program*: for boys who have witnessed domestic violence.

*Stabilization program*: short term stay programs for kids with or without CW status.

*Eastside Family Centres*: walk-in counselling.

*Phoenix*: for sex offenders.

*Eaglemoon Lodge*: for young Aboriginal people with substance abuse issues; meld treatment and cultural practices.

*The Catalyst Program*: for kids with very complicated mental illnesses.

*New Outlook*: for young people over 18 with mental illnesses.

*Alberta Mental Health Board*: Promotion and Prevention Division have developed some excellent resiliency and anti-stigma materials/campaigns that

could be replicated elsewhere e.g. Grip magazine for youth, Bounce Back book on toddler resiliency.

*Videoconferencing Initiative Pilot:* between Region and CFSA, Aspen Regional Health Authority, Child and Adolescent Services Association and community practitioners. This is a shared partnership to provide children and youth in the region with access to psychiatric, psychological and other interdisciplinary team support.

## **Saskatchewan**

*High Risk and Violent Young Offender Initiative:* evidence and knowledge based inter-sectoral forensic rehabilitation and treatment for high risk and violent young offenders.

*Parent Mentoring Program of Saskatchewan:* preventive intervention home visiting family support program for families with children from birth to the age of 5 living in disadvantaged conditions placing them at moderate psycho-social risk for poor outcomes in life.

*Early Skills Development Program:* intensive school and home based early intervention program for kindergarten and Grade 1 students with persistent and severe violent and aggressive behaviours.

*Mental Health Therapist Homes:* In Saskatoon our Community Resources (Central Region) offers Mental Health Therapist Homes that provide treatment foster care services for youth with both child protection and mental health needs. The child/youth and caregivers have the support of a mental health professional and immediate access to mental health services. We also partner with EGADZ (a Saskatoon CBO) to provide mentor-driven group home resources for sexually-exploited children and youth, many with mental health/addictions issues.

*Ehrlo Community Services:* delivers affordable, stable housing, recreation, vocational training, and counselling services to vulnerable populations in Regina.

## **Manitoba -**

*Centralized Intake for Youth Addictions:* Is a service that has been put in place to help families navigate services and match youth with an appropriate program for their needs. A toll-free number is available for people across the province to connect with addictions counsellors who will help them find services and supports.

*Co-Occurring Disorders Initiative (CODI):* Is an initiative to improve provincial capacity to provide service to individuals who have co-occurring mental health and substance use disorders. The project is jointly sponsored by the Addictions

Foundation of Manitoba (AFM), all Regional Health Authorities (RHAs) and Manitoba Health. This a model where both conditions are treated as primary disorders with parallel phases of recovery, interventions are individualized, and both the mental health and addictions systems staff are being trained to work together and to be able to work with clients with co-occurring disorders.

*Early Childhood Clinic:* Working with paediatricians, family physicians and the Provincial Day Care office of the Department of Family Services, an MATC multidisciplinary team provides assessment and brief treatment for families with infants, toddlers and children 5 years of age and younger.

*Early Psychosis Prevention and Intervention Service:* Identifies, supports and treats individuals between the ages of 13 to 25 years who are experiencing or recovering from a psychotic disorder.

## Ontario

*Multidimensional Treatment Foster Program:* developed through the Oregon Social Learning centre. This is evidence-based and considered a best practice. There are only three certified sites in the world at present.

*MST program:* MST program replicated from the original MST and respondent is a participant in the data collection of the University of South Carolina.

*Cognitive Therapy Clinic:* based on the beck model for CT. There are strong evidence indicators of its efficacy to date.

*Alternatives for youth program:* is included in the Health Canada compendium of best practices manual as an exemplary Canadian program. It has been replicated in other jurisdictions already.

*AI's Pals:* evidence based group program for pre-kindergarten youth. This program has shown strong results to date and we will be pursuing a partnership with the local school system to expand it.

*York Region's centralized consultation and assessment service:* where focus is system and organizations by providing trans-disciplinary clinical consultation on behalf of children and youth with complex or emerging mental health needs and/or who are deteriorating in their current service settings and environments, but who may not need the system's most intensive interventions if their issues can be identified, understood and addressed in a timely way.

*COMPASS:* integrated service model of capacity building and system change between boards of education and children's mental health.

*SNAP for Girls and SNAP for Boys:* Stop Now And Plan (SNAP) peer group intervention is a cognitive behavioural strategy taught to children in groups.

SNAP helps kids to regulate their angry feelings and to think before they act. It helps them to avoid fighting, handle peer pressure, stop stealing and play fairly. SNAP parenting helps parents to reduce the frequency and intensity of their children's behaviour problems. It helps them to monitor, encourage, reward and punish contingently.

### *Mothering After Violence*

*In-house psychiatric services:* Mainstream psychiatric facilities provide services to homeless youth within shelter settings. This promotes more effective opportunities for engagement with the youth in order to obtain a diagnosis and provide treatment.

*Triple P (Positive Parenting Program):* A research based program from Australia that is offered at a community wide level with 11 other service providers.

*Mindfulness Mixed Martial Arts* for LD and ADHD kids: very specialized with great outcomes

*Wait list management system:* by one respondent has proven to be very effective relative to the resources we have.

*Single Session Therapy (SST):* Ages 0 - 17 years inclusive - Counselling Services are out-client services for children and youth who are experiencing difficulties at home, in school or in the community. Clients appropriate for Counselling are initially offered Single Session Therapy during which a particular concern is discussed and recommendations made. Clients may choose to return for additional single sessions and after their third visit may choose ongoing treatment in Counselling.

*Valley Infant-Parent Program (VIPP)* Ages 0 - 30 months inclusive: The primary objective of The Valley Infant-Parent Program is to improve the quality of the caregiver-infant attachment relationship for at-risk infants. This service is provided in partnership with the Region of Peel, Children's Services and Peel Children's Centre. Caregivers and their infants attend a licensed, half-day program located at the Valley Child Care Centre. Involvement with the Valley Infant-Parent Program will also include access to a continuum of intensive, yet flexible in-home services. The program team consists of Resource Teachers, an Early Childhood Educator, access to a continuum of intensive, yet flexible in-home services and social work clinicians who will address needs in ways that build on individual and family strengths. All staff are trained in infant development, infant mental health, and attachment intervention to support positive relationships. Services will be provided in a comprehensive and coordinated manner. Psychological services also will be available.

*Preschool Services:* Ages 0 - 6 years inclusive - Preschool Services provides a range of strength-based services for children who are experiencing difficulties related to their behaviour, social relationships and emotions, and/or for children who have delays in communication or general development. Children who are currently attending, or wait listed to attend, a licensed childcare program are eligible. Services are flexible, tailored to meet identified treatment goals, and are provided mainly in the childcare setting or the family home by Early Childhood Educators, who can access the further services of a social worker and/or assessments by a psychologist, psychiatrist and speech-language pathologist.

*Alternatives to Day Treatment Services -* Ages 5 - 14 years inclusive - Alternatives to Day Treatment is a school-based service for children and youth who are dealing with a variety of mental health challenges that are putting them at risk of losing their school placement. Children and youth enrolled in either the Peel District or Dufferin-Peel Catholic District School Boards, within a defined geographic area, are eligible for the service. The service model seeks to provide in-class service to children and youth in their home school who require specialized treatment support but whose parents are currently unable to recognize or address their needs. Specific strength-focused interventions include the enhancement of self-esteem, social skills and positive peer and teacher interactions.

*Court Clinic Program -* Ages 12 - 18 years inclusive: Court Clinic Program provides assessment services for youth charged under Section 34 of the *Youth Criminal Justice Act* (2003) whose index offence(s) are committed when they are between the ages of 12 and 18 years. Court Clinic assessments assist Criminal and Family Court Judges in Peel with sentencing. The Court Clinic assessment process may include interviews with the youth and the family or legal guardian, psychological testing, family assessment, the integration of information from other relevant service providers, and a psychiatric evaluation when indicated. A report which summarizes the assessment and offers recommendations regarding the youth and the family/guardian is submitted to the Judge for consideration.

*School Community Intervention Partnership:* collaborative school program for younger children with externalizing behaviour problems

The Health-funded Child and Adolescent Mental Health Beds are funded through the hospital but are located in a children's mental health centre. Our program is the gate-keeper through the crisis team located in the hospital emergency department.

## Quebec

*Bourbonnière:* a group home for adolescents with a mental health diagnosis.

Formalizing programming for youth in need of protection and present with mental health issues.

*Suicide prevention:* prepared a guide about people at risk of suicide for front-line mental health staff and medical professionals.

### **New Brunswick**

*Youth Treatment Program:* for conduct disorders has proven to be quite popular. It engages the different partners in finding the best possible treatment plan/solutions for youth. There are 14 teams across the province with representatives from Mental Health, Addictions, Education, Public Safety and Family and Community Services.

*Pierre Caissie Center:* a six bed residential facility for assessments of conduct disorder youth. It can be accessed by the regional teams when all other community resources have been exhausted and assessment is deemed appropriate.

### **Yukon**

None listed.

### **Northwest Territories**

*FRIENDS for Life Resiliency Training* has been a great success. Community caregivers have enjoyed the training and are offering the program in diverse, remote, Aboriginal communities with (early reported) success.

### **Nunavut**

None listed

Most jurisdictions felt that there were numerous noteworthy programs that would be of interest to others. Several well-known programs, such as *Triple P* (Positive Parenting Program), *FRIENDS* anxiety prevention, and *SNAP* (Stop Now And Plan) were being used in multiple jurisdictions. There were also innovative programs developed at the community level to meet specific needs. Many of these are likely adaptable to other communities under the appropriate circumstances.

The breadth of programs offered that touch on child and youth mental health both directly and indirectly is a very good indication of the strong work being done and the understanding of the causes and implications of child and youth mental health on both the child or youth and his/her family.

Both Yukon and Nunavut did not list any programs from their jurisdiction.

## **C19 - In your opinion, what aspect of child and youth mental health service delivery needs the most improvement in your jurisdiction?**

### **British Columbia**

- specialized treatment programs for children and youth who have exhibited inappropriate sexual behaviours and have not been criminally charged
- further efforts to develop systems of care that are organized and integrated from a commonly held theoretical paradigm
- relaxation of the evidence-based criteria and recalibrate as “practice-based.”

### **Alberta**

- services to youth with both mental health and addictions issues
- early identification, screening and treatment
- infant mental health
- residential non-hospital based crisis stabilization and treatment
- increased funding
- residential treatment as a place of intensive concentration of particular issues rather than a place of last resort
- comprehensive understanding of needs and associated effective treatment to meet those needs
- standards for better meeting the needs of scheduled clients
- psychiatric and medical assessments for children and youth with challenging and complex needs, particularly in rural Alberta
- access to and appropriate discharge planning from psychiatric and medical beds (e.g. when children and youth are in a crisis)
- provision of ongoing mental health supports and services in partnership with other ministries to manage the complex and often lifelong mental health concerns of the child and their family
- provision of ongoing mental health supports for youth in transition with a dual diagnosis of mental health/developmental disability from the Children’s Services system to the adult mental health system
- waitlists for mental health services

### **Saskatchewan**

- access to child and youth mental health services where challenges such as geography, socio-economic status, racism/discrimination and/or lack of cultural competency exist
- residential services for children/youth with capable parents where there are no child protection concerns, but the child/youth cannot live at home
- immediate access to mental health professionals
- more in-patient mental health beds for children and youth (this is currently being expanded in the province)
- comprehensive continuum of services, including long term support and follow-up

## Manitoba

- capacity building in most remote communities
- crisis services
- school-based mental health supports
- transition to adult services
- expansion of timely mental health services for all children across the province

## Ontario

- funding (repeatedly mentioned)
- wait times (repeatedly mentioned)
- short term assessment and stabilization unit for youth with serious mental health concerns in our community
- resources to work with those on the front end of the mental health continuum
- integrated community planning and service delivery support
- service capacity to serve all new cases that are being identified through new programs
- new models of service for children/families with Dual Diagnosis and Aspergers
- early identification/early intervention
- linkage of community, medical and education-based services
- shift to evidence-based service, including outcomes measurement
- community accountability regarding programming across a continuum
- access to mental health services both on an inpatient and outpatient basis
- wraparound services that can deal with children with significant mental health needs
- services for youth in the 16-18 year old age category
- access to health professionals who can provide regular medication review and information to child welfare staff with respect to the side effects and consequences of long term use of medications to allow for well-informed decisions
- increase in number of clinicians who provide the ongoing therapeutic interventions needed after assessment
- hospital/crisis services for complex needs children

## Quebec

- early detection
- availability of specialized services
- access to a variety of different therapies
- early tracking of mental health problems
- link with adult services
- mental health promotion and prevention

### **New Brunswick**

- wait times

### **Yukon**

- increased professional resources for education, promotion and prevention
- increased clinical work

### **Northwest Territories**

- crisis stabilization services (almost non-existent at present)
- counsellors with specialized knowledge in child/youth mental health
- family therapy and in-home interventions need to be available in every community

### **Nunavut**

- outreach
- mental health workers
- diagnosis
- screening

This list of areas for improvement in child and youth mental health service delivery has many commonalities amongst jurisdictions. Wait times are an almost universal area for improvement, as are early intervention services. The commonalities across the country show a system of child and youth mental health that lacks true cooperation and integration, and requires a lot of change - some big changes and some small ones - to meet the needs of the children, youth and families using the services.

There are also many suggestions that are region or jurisdiction specific. These speak to the unique challenges within an area and the specificity of the respondents needs. It is important to understand how each respondent sees the system in which they work, in order to help build a better system for them to be a part of.

## CONCLUSION

Child and youth mental health is a very complex issue that is impacting families, schools, the health system and a multitude of other social systems which involve children, youth and their families. By conducting a national scan of policies, programs and services available, CWLC aimed for a better understanding of the current state of child and youth mental health across Canada. The results were not wholly different from the anecdotal commentary currently taking place in many places - there are pockets of coordination and integration in a variety of jurisdictions, there are wonderful programs being offered to children, youth and families in need of services, and there is a strong desire from all stakeholders to better meet the needs of clients. However, there is also a lack of early interventions, problematic wait times and a general shortage of resources, both financial and human, across the country.

A range of common themes emerge when the child and youth mental health systems from across the country are compared. Many jurisdictions noted the difficulties associated with reaching clients in remote areas of their province/territory. While strategies were often employed to overcome these obstacles, it is apparent that more work needs to be done to ensure coordinated and timely services reach children, youth and their families, particularly in remote parts of this country.

Wait times is one key area that continues to be a concern across Canada. The majority of respondents indicated it to be an issue for clients and this problem was repeated again when they were asked about areas needing the most improvement. Given the range of times some children and youth need to wait before receiving much-needed services, the severity of their problems may be exacerbated, causing increased stress on an already pressured system.

Capacity to meet the needs of clients was an area of improvement mentioned by many respondents, and this can impact wait times that clients are experiencing. Without enough qualified professionals, skilled in meeting the complex needs of this population, those who are able to provide services are doing so at capacity. Without increasing the number of qualified people to provide services and help these children and youth, wait times will not be significantly reduced. The reasons for this shortage are long and varied. Inadequate system funding repeats itself as a core reason for the shortage. However, in addition, there may be a lack of qualified practitioners willing to live and serve in remote communities to meet this very specific need, and/or a general lack of qualified child and youth mental health workers to fill positions should they be available. This is an area which requires further investigation. Regardless, without enough programs and services, for whatever reason, there will continue to be a high number of high needs children and youth seeking help and waiting a long time to get it.

It is well known the most effective way to treat a problem is to identify it early and begin treating it. Many jurisdictions offered some sort of early screening, but it was not necessarily consistently available or standardized in any meaningful way. Further to this, early intervention is one area that received much attention amongst the recommended areas for improvement. Service providers and government departments agree that it is important to help children and youth as early as possible, to lessen the chances of more serious problems in the future. Despite this agreement there is still work to be done to ensure it is a reality.

Coordination amongst service providers, with government departments, and coordination across the country varies considerably. The results of Section B indicate that some jurisdictions lack communication, both horizontal and vertical between service providers and government departments, that is necessary to ensure that all the needs of children and youth are being met. It is evident that development of partnerships with a view to promoting seamless and well-integrated child and youth mental health services is a critical objective. There is a need for comprehensive planning across all systems that work with children, youth and families, as well as clear leadership in promoting this direction. A number of provinces and territories have taken the initiative to develop these plans that will establish a basis for improved integration, monitoring and outcome measurement.

The link between research, policy and practice is well known. For example, Centres of Excellence have been developed across the country on a variety of topics with the explicit goal of bringing together researchers, practitioners, and policy-makers, to ensure that decisions being made and interventions being used are evidence-based. Sound research is required to ensure that children are being served as well as they can be. The support of research agendas in a number of jurisdictions is very encouraging as service providers and governments welcome the opportunity to use the most current and advanced knowledge to make decisions regarding how best to work with children, youth and their families. Concerning are those organizations that do not have access to expertise or research, nor actively engage in research. For service delivery organizations, program evaluation is key to understanding how effective an intervention is, and just as importantly, why the intervention is successful or not. For governments, without sound knowledge of current research, policy decisions, which have far-reaching program and funding implications, are impacted and the quality of care across an entire jurisdiction could be called into question. In the information age where technology allows for relatively easy access to current information, there are now opportunities for the development of research agendas.

There is much work to be done to bring the child and youth mental health system to the level it needs to be to fully meet the needs of children, youth and families. At present there appears to be a real lack of partnerships and

cooperation within sectors and across. Now is the time for these gaps to be addressed and the needs of children, youth and their families to be met. Governments and service delivery agencies alike need to come together to find solutions to the challenges being faced. As this continues to happen, the exchange of ideas, skills and knowledge will help foster a comprehensive system of child and youth mental health across Canada. Without this coordination provinces and territories will continue to see a patchwork of services and organizations without sufficient integration and leadership to help those who need it the most.

Based on the results of the national scan and the themes that emerged, the following recommendations are put forward in an effort to strengthen the child and youth mental health systems across Canada.

#### Recommendations:

##### Provincial/Territorial Planning

1. Each jurisdiction is encouraged to develop a child and youth mental health plan that promotes the development of comprehensive, well integrated, inclusive and accountable services for prevention, treatment and follow-up.

##### Networks

2. Government departments who have responsibilities for children and/or families should consider forming linkages and/or partnerships with each other on child and youth mental health.
3. A network of service providers would be beneficial to contribute to the sharing of information, knowledge and resources.
4. Partnerships between governments and service providers would help ensure that policies, and programs and services being offered across the province/territory are meeting needs and producing the desired results.
5. All sectors who are involved with children or youth who may require child and youth mental health services should investigate ways of coming together to coordinate services, programs and policies. This includes service providers and government departments.
6. Knowledge sharing across jurisdictions at the senior level would help advance child and youth mental health at a national level.

##### Wait Times

7. Measuring wait times can help jurisdictions determine appropriate service levels.

8. The issues related to rural and remote populations ought to be considered in child and youth mental health planning.

Research

9. Access to up-to-date research and/or expertise related to child and youth mental health would benefit service providers and government departments.
10. Evidence-based decision making is a valuable method of decision-making and is very applicable in the field of child and youth mental health.

Leadership

11. The creation of a national Centre of Excellence for Child and Youth Mental Health to link with the emerging provincial initiative would benefit the field of child and youth mental health across the country.