

Select Standing Committee on
Children and Youth

Final Report
Child and Youth Mental Health in British Columbia

Concrete Actions for Systemic Change



JANUARY 2016



January 26, 2016

To the Honourable
Legislative Assembly of the
Province of British Columbia

Honourable Members:

I have the honour to present herewith the Third Report of the Select Standing Committee on Children and Youth for the Fourth Session of the 40th Parliament.

The Report covers the second phase of the Committee's work in regards to child and youth mental health in B.C. and was approved unanimously by the Committee.

Respectfully submitted on behalf of the Committee,

Jane Thornthwaite, MLA
Chair

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Composition of the Committee

Members

Jane Thornthwaite, MLA	Chair	North Vancouver-Seymour
Doug Donaldson, MLA	Deputy Chair	Stikine
Donna Barnett, MLA		Cariboo-Chilcotin
Hon. Mike Bernier, MLA (to September 28, 2015)		Peace River South
Marc Dalton, MLA (from September 28, 2015)		Maple Ridge-Mission
Carole James, MLA		Victoria-Beacon Hill
Maurine Karagianis, MLA		Esquimalt-Royal Roads
John Martin, MLA		Chilliwack
Dr. Darryl Plecas, MLA		Abbotsford South
Jennifer Rice, MLA		North Coast
Dr. Moira Stilwell, MLA		Vancouver-Langara

Committee Staff

Kate Ryan-Lloyd, Deputy Clerk and Clerk of Committees

Helen Morrison, Committee Research Analyst

Alayna van Leeuwen, Committee Research Analyst

Terms of Reference

On February 11, 2015, the Legislative Assembly agreed that the Select Standing Committee on Children and Youth be appointed to foster greater awareness and understanding among legislators and the public of the BC child welfare system, and in particular to:

1. Receive and review the annual service plan from the Representative for Children and Youth (the “Representative”) that includes a statement of goals and identifies specific objectives and performance measures that will be required to exercise the powers and perform the functions and duties of the Representative during the fiscal year;
2. Be the committee to which the Representative reports, at least annually;
3. Refer to the Representative for investigation the critical injury or death of a child;
4. Receive and consider all reports and plans transmitted by the Representative to the Speaker of the Legislative Assembly of British Columbia; and,
5. Pursuant to section 30 (2) of the Representative for Children and Youth Act, S.B.C. 2006, c. 29, complete an assessment by April 1, 2015, of the effectiveness of section 6 (1) (b) in ensuring that the needs of children are met.

In addition to the powers previously conferred upon Select Standing Committees of the House, the Select Standing Committee on Children and Youth be empowered:

- a. to appoint of their number one or more subcommittees and to refer to such subcommittees any of the matters referred to the Committee;
- b. to sit during a period in which the House is adjourned, during the recess after prorogation until the next following Session and during any sitting of the House;
- c. to conduct consultations by any means the committee considers appropriate;

- d. to adjourn from place to place as may be convenient; and
- e. to retain personnel as required to assist the Committee;

and shall report to the House as soon as possible, or following any adjournment, or at the next following Session, as the case may be; to deposit the original of its reports with the Clerk of the Legislative Assembly during a period of adjournment and upon resumption of the sittings of the House, the Chair shall present all reports to the Legislative Assembly.

Executive Summary

In Fall 2013, the all-party Select Standing Committee on Children and Youth agreed to undertake a special project examining child and youth mental health in British Columbia. The Committee's November 2014 Interim Report on its first phase of the special project summarized the results of extensive consultations undertaken by the Committee, and identified six high priority areas needing improvement.

The Committee's second phase of work launched in February 2015 focused on identifying concrete and practical initiatives to enhance child and youth mental health services and outcomes in BC. The Committee undertook additional consultations in the form of public hearings with invited witnesses and an opportunity to make written, video or audio submissions via the Committee's website.

The Committee's recommendations in this report are the result of the past two years of work on issues affecting child and youth mental health and ways to improve child and youth mental health services in British Columbia. The Committee heard that we have many services available, but they are often not necessarily easily accessible, or well integrated as a system of care. Children, youth, young adults, and their families are suffering as a result of significant weaknesses and gaps in services.

Improvements to the delivery of mental health services are urgently needed. Acting now to improve mental health services could reduce the consequences of mental illness in our youth population and its impact on the economy and society.

Members agreed that changes to governance and accountability for child and youth mental health services are needed to ensure the coordination and effectiveness of services. The Committee's first core recommendation is that a new Minister for Mental Health be appointed to assume responsibility for the funding and coordination of mental health services in the province. It is time for mental health

I really believe that we can build the best system in the world ... we have so much already on the ground, but it's just not integrated and working with each other. I don't think it would take a lot of investment to make a real difference and to get youth in this province knowing where to go when they need help.

Dr. Steve Mathias, Presentation to the Committee, June 24, 2015

to be given a higher profile and more attention, and a new Cabinet level portfolio for mental health services would help to achieve that objective.

The Committee's second core recommendation is for an integrated service delivery model. The Committee considers that many of the most promising solutions for improving child and youth mental health integrate and coordinate services. This "one child, one file" approach should be a foundational design principle for the child and youth mental health system.

To this end, the Committee received evidence about innovative new models which are successfully delivering integrated child and youth mental health services. North Vancouver's Mountainside Secondary School, the Cariboo Collaborative (Cariboo Action Team), and the Inner City Youth Mental Health Program are school- and community-based service hubs with accessible, youth friendly "one-stop shops." The Committee recommends that existing integrated service delivery programs be given multi-year funding. Moreover, the Committee recommends that a multi-year pilot project approach be used to quickly launch more integrated, collaborative, and multi-disciplinary school- and community-based "hubs" to deliver mental wellness programs and clinical and social services to children, youth, and young adults. Lessons learned from pilot projects would provide a basis for expanding these models across the province.

The Committee heard about specific gaps and barriers to effective service delivery, and identified the following initiatives to strengthen service performance:

- Linking funding for child and youth mental health services to integrated service delivery.
- Services must be delivered in a timely manner and the Committee recommends that targets be established to ensure that children, youth, and young adults identified as exhibiting signs of behavioural, emotional, or mental health issues are assessed within 30 days and begin receiving treatment within the next 30 days.
- Services must be child- and youth-friendly and the Committee recommends that youth have input into the design of programs, and that

ongoing feedback be sought through client satisfaction surveys. Given technology usage among children and youth, investments in online mental health programs designed for youth and young adults should be increased, and connectedness initiatives in schools supported.

- Problems related to the availability and funding for the full spectrum of care were identified. The Committee recommends more support for mental wellness programs in order to avoid the problems and costs of more serious illnesses later on. Early intervention and prevention are critical and the Committee recommends funding be provided to early intervention programs so that problems are identified sooner and children and youth get the help they need sooner.
- There must be adequate, appropriate clinical services. Stronger linkages between health authorities, other health care providers, and school districts, need to be developed. Emergency departments are often the initial point of contact for children and youth seeking mental health services. The quality of first contact in emergency departments should be improved by employing registered psychiatric nurses more broadly and ensuring proper discharge planning to outpatient follow-up care. Alternatives to emergency departments for urgent/acute psychiatric care such as Assertive Youth Treatment teams should also be established. The Committee makes recommendations to improve access to services provided by child and adolescent psychiatrists and psychologists. The delivery of clinical services to rural and remote areas should be expanded through technology such as telehealth.
- The Committee considered issues around transition-age youth and young adults and recommends that eligibility for child and youth mental health services be extended to young adults. The Committee also heard about vulnerable populations that need special attention. These include Aboriginal children and youth, sexual and gender minority youth, children in care, and special needs children and youth. School districts should be required to support sexual and gender minority youth in schools through general and targeted programs to address child and youth

mental health issues. The Committee recommends that all children in care have access to mental wellness programs and early intervention programs and services and that culturally appropriate programs and services for Aboriginal children and youth be publicly funded.

The Committee urges that its unanimous recommendations for concrete actions to improve child and youth mental health services be undertaken by government as a matter of high priority.

The Work of the Committee

Special Project: Child and Youth Mental Health in British Columbia

The all-party Select Standing Committee on Children and Youth (the Committee) was established in 2006 to implement the second recommendation of the Honourable Ted Hughes in his 2006 “BC Children and Youth Review” – the first recommendation being to establish a Representative for Children and Youth. Former Justice Hughes stated that an all-party Committee would “encourage Government and the Opposition to work together to address the challenges facing the (children and youth) system.”

The Committee’s Terms of Reference continue to set out its overarching purpose of fostering “greater awareness and understanding among legislators and the public of the BC child welfare system,” and responsibilities regarding its relationship with the Representative for Children and Youth.

Within this mandate, the Committee met in Fall 2013 with the Representative for Children and Youth to discuss her review of mental health services for youth, titled *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.* (April 2013). The review acknowledged progress in providing child and youth mental health services, but identified significant gaps, barriers, and areas for improvement to meet the serious challenges across the province.

Given the importance of the issue and the concerns identified by the Representative, Committee Members agreed in Fall 2013 to launch a special project examining child and youth mental health in British Columbia. Public meetings were held with expert witnesses representing all sectors and regions of the province, a private meeting was organized with youth and families, and written submissions from the public were invited. In November 2014, the Committee issued an Interim Report highlighting six priority areas for attention: improving youth mental health services; integrating service delivery; ministry leadership; education and school supports; community-based services; and ending the stigma against mental illness.

In February 2015, the Committee began the second phase of its work on the special project, focusing on concrete and practical solutions to the challenges identified in its Interim Report.

Consultation Methods

For the second phase of the special project, the Committee invited witnesses to several in-person meetings. To focus on generating solutions related to the six priority areas identified in the Interim Report, the Committee asked specific questions to identify promising strategies and solutions, reflecting each witness' role in child and youth mental health, including educators, police, and clinicians. A total of 23 presentations were made to the Committee at five public meetings between April 13, 2015 and June 24, 2015. The names of the presenters are listed in Appendix A.

Through its website, the Committee invited written, video, and audio submissions from anyone who was interested in contributing to the Committee's work. An online submission form and the following consultation questions were provided:

- How could services for early intervention, assessment, treatment, and prevention of youth mental health issues be improved and/or integrated?
- What new or enhanced community-based services is your community working on to better meet local needs? What are needed?
- What services and supports are needed in schools to improve education, assessment, and treatment of youth mental health issues? What is your school district doing to help?
- What actions are you taking to reduce stigma around youth mental health?

The names of the 71 individuals and organizations that provided written or video submissions are listed in Appendix B.

In developing its conclusions and recommendations, the Committee considered input from the first and second phases of its work. The 153 oral and written submissions from the first phase provided a foundation for the development of concrete and practical recommendations included in this report.

The Committee is very grateful to all those individuals and organizations who shared their experiences and expertise with the Committee. Members greatly appreciate their assistance in furthering their own awareness and understanding of child and youth mental health services in the province. The presentations and submissions depicted strengths and weaknesses of the current framework and proposed ways to improve child and youth mental health services.

Schedule of Meetings

February 12, 2015	Organization and Planning	Victoria
February 17, 2015	Organization and Planning	Victoria
March 4, 2015	Organization and Planning	Victoria
March 25, 2015	Organization and Planning	Victoria
April 13, 2015	Child and Youth Mental Health Briefings	Victoria
May 6, 2015	Child and Youth Mental Health Briefings	Victoria
May 27, 2015	Briefing by Ministries and Child and Youth Mental Health Briefings	Victoria
June 23, 2015	Child and Youth Mental Health Briefings	Vancouver
June 24, 2015	Child and Youth Mental Health Briefings	Vancouver
July 16, 2015	Deliberations	Victoria
September 30, 2015	Deliberations	Victoria
November 23, 2015	Deliberations	Vancouver
January 25, 2016	Deliberations	
	Adoption of Report	

The Committee's documents, proceedings, and this report are available at: <https://www.leg.bc.ca/parliamentary-business/committees/40thparliament-4thsession-cay>

Briefing by Ministries

Child and youth mental health programs and services have evolved in British Columbia as a network of diverse services provided in community, hospital, and residential care settings. In the 1970s, services were expanded and decentralized, and enhanced in the 1990s to improve accessibility and preventive programs. In 1999, government launched consultations with stakeholders, experts, and clients on a strategy to develop a renewed child and youth mental health plan. The plan was announced in 2003 making child and youth mental health a cross-government issue requiring more resources, planning, community engagement, partnerships with schools and health providers, and leadership from the Ministry of Children and Family Development.

The Ministry of Health has seen an average 2.9% increase per year in the number of children and youth with mental health diagnoses accessing a broad range of Ministry of Health funded services. Between 2009 and 2013, BC has seen a 43% increase in the number of children, youth, and young adults aged 0-24 presenting to hospitals to seek mental health and substance use services ... those aged 15-19 have the greatest rate of increase (73 % increase between 2009 and 2013).

Joint Ministry Written Submission,
July 2015

The Committee received a joint presentation on May 27, 2015 on child and youth mental health from senior officials of the Ministries of Children and Family Development, Health, and Education. The Committee also received a joint written submission in July 2015 from the Ministires of Children and Family Development, Advanced Education, Community, Sport and Cultural Development, Education, Health, Justice, and Social Development and Social Innovation. Ministry officials outlined the current state of child and youth mental health needs across the province, progress in responding to these needs, key gaps in support, and actions underway and future directions to strengthen child and youth services in British Columbia.

The Committee heard that across the province approximately one in eight children and youth may be affected by mental illness, causing distress and impairing functioning at home, school, and in communities. Moreover, child and youth mental health needs are increasing in number and complexity.

Given the complexity and range of child and youth mental health needs, collective action by a variety of ministries aims to provide a holistic system of care. The system uses a “stepped” model of care which aligns service intensity with need, and uses more specialized services to address higher level needs. Integrated and flexible service delivery aims to provide the best fit for children and youth mental health requirements.

Ministry officials acknowledged to the Committee that key gaps exist in the areas of prevention and early intervention, wait times, emergency department capacity, substance abuse programs, and vulnerable populations. Addressing these gaps is a government priority.

Collaboration among ministries involved in child and youth mental health is an important principle for service governance and delivery. Ministry officials advised that “no matter how systems are organized and governed, there is always a need for ministries to work collectively and in partnership with other governmental and non-governmental services.”

Ministry officials briefed the Committee on examples of initiatives to strengthen child and youth mental health services, including immediate support and preventive interventions.

- To meet the challenge of increased demands on emergency departments in some communities, community capacity to reduce demands on emergency departments is being enhanced through integration of primary and community care, hospital-

(Given) the complexity in terms of meeting the needs of children and youth and their development that changes over time, there really is no one path. The experiences of children and youth and their families are so unique that there are many different pathways Ideally, our goal is to avoid children and youth even needing to receive the services, making sure that we are implementing prevention interventions and supporting positive mental health as much as we can in settings like schools, in community centres and in homes.

Sandy Wiens, Ministry of Children and Family Development,
Presentation to the Committee,
May 27, 2015

community protocols, and the development of services for children and youth with complex care needs.

- To address youth substance service gaps, system and service capacity is being upgraded, with new Community Substance Use program spaces, provincial standards for services, and guidelines for withdrawal management.
- To assist vulnerable children and youth, priority needs of vulnerable groups are being enhanced with LGBTQ (lesbian, gay, bisexual, transgender, and queer) workshops, practices to support inclusion, access for Aboriginal children and youth, and strengthened data collection.
- To provide more consistent cross system coordination/collaboration/integration, broader implementation of integration models is being explored, information sharing is being improved, transition protocols are being developed, and increased involvement is being provided through more Parents in Residence positions and increased family-centred practices.

Ministry officials recognized that there is more to do. The Ministry of Children and Family Development is leading a working group with other ministries to review Child and Youth Mental Health Services, and to make recommendations to Cabinet by June 30, 2016 on potential improvements. The recommendations will “be inclusive of youth up to age 24 years and will be based on a system-wide review of service needs and service gaps,” and will involve input from families, academic experts, and community and physician partners.

Public Consultation

Results

The Committee's public consultation process engaged experts, stakeholders, and individual British Columbians in the Committee's work to review child and youth mental health services, and identify concrete and specific ways to strengthen and support them.

Throughout its consultations, the Committee was struck by the wide-reaching effects of mental illness: the suffering of children, youth, and their families; and the unmet potential of children and youth experiencing mental health problems. The Committee heard how BC's established network of child and youth mental health services provides essential help, and where improvements are required to address significant weaknesses and gaps.

*How many more kids can we spare
before something is done to combat
these issues?*

Katherine Harris, Video Submission

The evidence presented to the Committee led Members to conclude that urgent action is required. The children, youth, and young adults of British Columbia are currently not being adequately served by the existing level and structure of service delivery. Given the critical importance of early and formative years to success in adulthood, it is imperative that the existing deficiencies in mental health services be addressed as quickly as possible.

Leadership and Accountability

The issue of leadership and accountability in child and youth mental health was raised in several submissions, including a recommendation to transfer responsibility for Child and Youth Mental Health Services from the Ministry of Children and Family Development to the Ministry of Health. For example, the BC Psychiatrists Association expressed the view that the Ministry of Health was doing good work in expanding telehealth for rural areas, and that moving Child and Youth Mental Health Services to the Ministry of Health could improve service delivery by using telehealth approaches.

Proponents of a consolidation of child and youth mental health leadership and programs within the Ministry of Health indicate that such a reorganization could result in the following advantages:

- Consolidation of funding for and the delivery of all mental health services, since children and youth frequently first access mental health services in physicians' offices, walk-in clinics, and hospitals;
- Consolidation would build on the Ministry of Health's work to provide out-patient youth addiction services to support mentally ill youth, many of whom struggle with alcohol and drug dependencies;
- Funding for child and youth mental health services might be enhanced if core services were the responsibility of the Ministry of Health;
- Barriers to access could be reduced because some families will not approach the Ministry of Children and Family Development for assistance with child and youth mental health issues given the Ministry's ability to remove children from their home, or due to existing strained relationships over other child custody and protection issues;
- Consolidation could allow for more consistency of services between primary and community services if it was under one ministry;

- Consolidation could improve the broader deployment of telehealth programs in rural and remote areas; and
- Consolidation could facilitate more integrated service delivery, most critically, for transition-aged youth and young adults up to the age of 25.

On the other hand, a reorganization of programs into the Ministry of Health could have adverse implications:

- It may be costly and disruptive to undertake a ministry restructuring;
- The transfer may not be any more likely to result in the kind of multi-setting, multi-disciplinary collaboration that is needed and is already partially underway;
- Child and youth mental health services might be overwhelmed by other Ministry priorities;
- Funding and delivering services through the Ministry of Health could promote a “medical model” of care, under which mental health may tend to be defined as an absence of mental illness, with heavy focus on medication and intensive treatment for serious mental illnesses rather than prevention and early intervention; and
- Having the services in a child and youth-serving ministry is more likely to facilitate a holistic view of child and youth wellness, with consideration for the interdependent individual, familial and social determinants of health.

The Committee heard evidence suggesting that, on balance, a major reorganization of child and youth mental health roles and responsibilities within an existing ministry may not result in better service. Dr. Charlotte Waddell of Simon Fraser University’s Children’s Health Policy Centre said that the Ministry of Children and Family Development is “the one central ministry with the mandate to provide programs through the community, especially these psychosocial programs which, in general, are more effective for children.” She also noted that the ministry was “well able” to lead BC’s ground breaking 2003 five-year child and youth mental health plan, including bringing together the Ministries of Health and Education. While she felt something is currently missing in terms of leadership and momentum, the plan “was done, and it was done well. That’s the one place where, perhaps, there has always been that capacity to look at the full picture for the province.”

The Importance of Integrated and Coordinated Service Delivery

Presentations made to the Committee revealed the wide variety of services which have emerged to improve the mental health of children and youth. The Committee also heard of the urgent need for better integration, coordination, and collaboration to make the availability of current services better known and more effective in meeting the needs of children, youth, and their caregivers. Frustrations with finding, navigating, and accessing services – and in some cases, finding no appropriate local services – were a top concern raised by caregivers and youth.

For many mental illnesses, evidence points to the benefits of early intervention for child and youth well-being. Early intervention can also result in significant long-term savings. However, since financial savings can be difficult to quantify, it can be difficult to orient funding toward early intervention. For example, the Committee heard that a nurse-family partnership can save \$18,000 per family over 10-15 years. Dr. Charlotte Waddell noted that “these are costs that you don’t have to spend on emergency room visits, hospitalizations of children with injuries, doctors visits, social assistance, taking kids into foster care, taking moms and kids into the justice system.”

Missed appointments are a simple, but tangible, example of wasted resources. Uncoordinated services and unrealistic service delivery models can result in wasting clinicians’ time. It can be extremely unrealistic to expect a troubled youth, or a youth with specific barriers like a lack of transportation, to attend appointments at clinicians’ offices.

The hospital is under the Ministry of Health. When they’re back out in the community, they’re under MCFD (the Ministry of Children and Family Development). So different mandates, different standards, different philosophies of care, different systems, different computer platforms.

Dr. David Smith, Presentation to the Committee, June 24, 2015

Throughout the mental health system, whether we’re talking about the adult system or the child and youth system, we are making choices of where we spend money. Right now we would say that we’re spending it ... in policing, we’re spending it in jails, and we’re spending it in unnecessary hospitalizations for children and youth.

Bev Gutray, Canadian Mental Health Association, Presentation to the Committee, June 24, 2015

We’ve been accessing some of our PharmaCare data, some of our hospital data and MSP data. We’re starting to build a picture of the youth. We are particularly concerned about the increase in emergency rooms ... because ER rooms are not the right place for youth to come who are maybe having some sort of an episode with their mental health at that time.

Doug Hughes, Ministry of Health, Presentation to the Committee, May 27, 2015

The question I always have is: how much money is lost in inefficiencies? You know, I book an appointment for a kid who's totally at risk, and I sit in my office and I wait for them, and they never come, and that hour-long slot is now gone because I can't book it for everybody else, but I'm still getting paid my salary during that time.

Jeremy Church, Mountainside School, Presentation to the Committee, May 6, 2015

By some estimates, between 40 to 70 percent of visits to primary care physicians are behavioural, emotional or otherwise psychological.

BC Psychological Association and BC Pediatric Society, Joint Written Submission

Instead of talking about referrals and wait times, we talk about access ... Sometimes we wait too long, and there are times when we overintensify when we shouldn't. But actually meeting when the child and youth and family are ready is responding in a timely manner so we can prevent the escalation of concerns.

Dr. Bill Morrison, Presentation to the Committee, April 13, 2015

Hospital emergency departments are increasingly becoming a key point of access for acute psychiatric care, frequently because it is the easiest and fastest way to get care for a child or youth in crisis.

However, poor discharge planning may mean that the emergency visit fails to result in necessary follow-up services being made available to youth.

Family physicians play a critical role in early identification of mental illnesses and in prescribing medication. They are often very well-placed to refer their patients to more specialized services if they exist in the community. However, billings by physicians under BC's Medical Services Plan for other kinds of mental health treatments may not be the most cost-effective delivery of services. Additionally, some communities do not have enough physicians to meet the demand for medical treatment.

Public submissions to the Committee attested that a multi-disciplinary approach is required. Services should be provided by the right practitioner and accessed at the right intensity at the right time. It is hard to imagine the possibility of receiving the "wrong" level of service when parents may be desperate for any service at all. However, inappropriate and/or delayed referrals can and do happen, and are often not efficient and not in the best interest of the child or youth. Even more troubling is that referrals may not be made at all when there is a lack of cooperation and coordination between health authorities and other health care providers.

Policing and justice costs related to mental illness are significant and appear to be growing. Whether it is the number of "mental health calls" attended by police, or the costs of having mentally ill youth in custody, police are increasingly sounding the alarm over this issue. Chief Officer Neil Dubord of the Delta Police observed that "24-7 care is currently handled by police, obviously — we become the de facto agency to be able to manage that — and a

hospital's ER," and reported that one in every five calls attended by police involves some form of mental health issue. The human health and safety costs are also significant: harm to victims and families, and potentially harm to the mentally distressed people who are police-involved or who commit crimes.

Use of pharmacological interventions appears to be growing. Psychotropic medications are a necessary and possibly life-saving part of treatment for a number of mental illnesses. Few, if any, parents would take lightly the decision to medicate their children, though in the absence of good information and a spectrum of alternative or complementary treatments (such as cognitive behavioural therapy or other types of counselling), parents may be inclined to accept medication, if it is offered. It is concerning to imagine medication used as the first or only resort in supporting children and youth with any number of behavioral difficulties, mental distress, and mental illnesses. The Committee also heard concerns about the potential influence of companies marketing psychotropic medications on physicians' choices for strategies to assist their patients, and generally influencing social perceptions of what effective treatment of mental illness should involve.

Use of medication for some illnesses is also concerning in the long term given the lack of evidence of the possible impacts on children's developing brains. Longer term financial and human costs of over-reliance on, or inappropriate use of, medication are unknown.

Insufficient data, the Committee believes, present a significant barrier to re-orienting system resources in a more productive way. Investing in broad awareness and prevention strategies might be more cost-effective in the long term, but without strong evidence it is difficult to prioritize preventive and early intervention programs over meeting immediate needs such as adequate police resources to deal with "mental health calls" to police. As Dr. Charlotte

It's impossible to capture the resources from all the different service providers from the time the youth was 12 years old and had his first interaction with the system ... mental health problems were suspected and recorded by police school-resource officers at the age of 13. Yet a lack of coordination and capacity of the system prevented us from stopping a homicide seven years later.

Chief Officer Neil Dubord, BC Transit Police and Delta Police, Presentation to the Committee, June 23, 2015

We're not listening to the powerful communication that children and youth are offering ... we say they've got to be fixed with drugs, because that's the tool, the blunt instrument, we have at hand. These intense emotions usually arise from compelling reasons ... abuse ... bullying ... a struggle to cope in a developmentally difficult environment. Maybe it's just the normal, the difficult human task of trying to forge a viable path into the future in the project we call life.

Reverend Dr. Steve Epperson, Presentation to the Committee, June 24, 2015

Because we do not know what the long-term effects of psychiatric medications are on the growing brains of children, we believe they should be rarely used and for the shortest possible time.

Alan Cassels, Rob Wipond and Janet Currie, Joint Written Submission

One notable area of challenge in this area is the tracking of outcomes for children and youth who are receiving services ... what we don't have is a common or core set of outcome indicators that is routinely collected and that can be used to help with systems-level planning.

Mark Sieben, Ministry of Children and Family Development, Presentation to the Committee, May 27, 2015

... at the community-based level there are private practitioners, like psychologists and clinical counsellors, working in the community, and there isn't a mechanism currently for us to collect information about how many children or youth they see and exactly what services they're providing.

Sandy Wiens, Ministry of Children and Family Development, Presentation to the Committee, May 27, 2015

Waddell noted, “clearly tracking the benefits for children, or clearly demonstrating insufficient programming, could help increase public support for new investments in promotion and prevention.”

In their presentation to the Committee, Ministry officials acknowledged that ministries only have incomplete, poor quality data. This hinders the development of performance measures and system planning.

An official from the Ministry of Health also indicated that it is very challenging to obtain data and that the Ministry looks to other sources, including the police.

Models of Integrated Service Delivery

The Committee heard evidence of integrated, coordinated services which highlight the value of more holistic services designed around the needs of the child, youth, and family and what works best in terms of making the services accessible. These examples illustrate possible ways of promoting more efficient and cost-effective use of resources.

The Committee received presentations on three particularly strong, made-in-BC examples of integrated service delivery as well as two noteworthy examples in other jurisdictions – a provincial model in New Brunswick, and a national approach in Australia.

Mountainside Secondary School

Mountainside Secondary School is an alternative school in North Vancouver that launched a new vision for supporting students with multiple complex needs, including mental health support, in 2012. Approximately 180 students (85% of which have a Special Needs Designation) have been referred by the District Resource Team to this innovative model school to de-stigmatize perceptions of “alternative schools.” Teachers act as case managers for 10-15 students, helping connect students to on-site services such as the Therapeutic Day Program (a partnership with Vancouver Coastal Health), the Concurrent Disorders Program, onsite physician and nurse appointments, restorative justice programs, music therapy, and childcare for young parents.

A key underpinning of Mountainside’s approach is the recognition that challenges facing students and their families are systemic – mental wellness, physical health, housing, food, employment training, and social connections are all needed to effectively support students. Mountainside Principal Jeremy Church noted that “an integrated approach to service begins to remove some of the perceived or existing barriers to service for youth and their families” (e.g., transportation, unknown environments, systemic mistrust, and duplication of services). One of Mountainside’s future goals is continued expansion of the “one-stop shop,” and replication of the model (or elements thereof) elsewhere in the district. For example, active case management practiced at Mountainside could benefit all youth with mental health needs, not just Mountainside students.

You could paint the picture of the perfect alternate school — supportive, caring, on-site supports, all this stuff — and recognize that should just be school in general. It shouldn’t just be alternate schools.

Jeremy Church, Mountainside Secondary School, Presentation to the Committee, May 6, 2015

...co-location has encouraged a “wrap around approach” ... when community services can be accessed by simply walking down the hallway.

Dr. Glenn Fedor, Cariboo Action Team and Nancy Gale, Cariboo Chilcotin Child Development Centre Association, Joint Written Submission

Integrated service delivery takes time, energy and strategies to manage risk and should not be viewed as a short term solution...

Dr. Glenn Fedor, Cariboo Action Team and Nancy Gale, Cariboo Chilcotin Child Development Centre Association, Joint Written Submission

Rather than create a “new” Triple P partnership ... of doctors, property developers and large international health care not for profits ... we are ... suggesting that a fourth partner, Community Service Organizations be included in the ... system that only recognizes health authorities, school districts and the Ministry of Child and Family Development as key partners.

Dr. Glenn Fedor, Cariboo Action Team and Nancy Gale, Cariboo Chilcotin Child Development Centre Association, Joint Written Submission

We need to shift some of our focus to children between the ages of 16 and 25 (so they do not) end up ... becoming the million-dollar babies ... in other systems.

Nancy Gale, Cariboo Chilcotin Child Development Centre Association, Presentation to the Committee, June 24, 2015

Cariboo Collaborative (Cariboo Action Team)

Representatives of the Cariboo Action Team highlighted a horizontal multi-disciplinary community integration approach to child and youth mental health services, including involvement of community service organizations.

The Cariboo Chilcotin Child Development Centre is a signature achievement under this model. The Centre, an integrated community service hub for children and youth, has co-located clinicians -- such as a pediatrician, an emergency physician with a child and youth mental health and addictions specialist, and a child psychiatrist. Occupational therapists, physical and speech language therapists, early childhood educators, and autism interventionists also work out of the hub.

Co-location has led to economic efficiencies (space-sharing, shared services), and a “wrap around” approach, making services much easier to access. The Cariboo Action Team has plans for building on the success of this model, but a lesson from the Team’s experience in building this innovative service hub is that it is not easy to initiate or sustain a new way of doing business.

The “Collaborative” has expanded to other health authorities and is funded by the Doctors of BC and the Ministry of Health, but they indicate that more system collaboration is required at all levels to enhance the current models.

Inner City Youth

Mental Health Program

Dr. Steve Mathias' presentations to the Committee during phase one and phase two included a profile of the Inner City Youth Mental Health Program, an outreach service from St. Paul's Hospital in Vancouver. The program, the largest of its kind in North America, uses an intensive case management-based approach to provide access to services of nurses and social workers, psychiatrists and a psychosocial rehab team, as well as 80 low-barrier housing units provided in partnership with BC Housing. Dr. Mathias suggested there could be a network of three or four hubs in each health authority where primary care, public health, mental health, substance use, income assistance, and housing could be provided to youth on site.

While each of these three made-in-BC examples presents a slightly different way of integrating and coordinating services for the needs of the particular community or population, the Committee considers them to be exemplary models of how services should be designed. In each case, they appear to be locally-driven, ground-up or grassroots initiatives that are successful in part because of the tremendous efforts and commitment of specific individuals spearheading the initiatives.

The Committee discussed whether these examples could become the norm rather than the exception under a framework that expects and rewards integrated service delivery.

... the inner-city youth program was designed basically to pick up the homeless and marginally housed youth ... What we discovered was that the youth were being discharged from the emergency room ... without any follow-up. Last year we had close to 1,800 young people present with mental health and addiction issues ... they had nowhere to go. So we designed a program specifically dealing with that population ... and we started to understand what the challenges were.

Dr. Steve Mathias, Presentation to the Committee, June 11, 2014

Without a comprehensive strategy and structure in place, good work can still happen, but it happens on the back of personal relationships. ... We need to give permission to those organizations to work together, and we need to give them time to work together.

Dave Mackenzie, BC School Centred Mental Health Coalition, Presentation to the Committee, June 23, 2015

One of the things that had to happen and that was very effective was there was an ISD (Integrated Service Delivery) mandate agreement ... signed by every deputy minister and ADM in the four ministries as well as the vice-presidents of the regional health authorities that said "We will be part of this. We will put this not at the side of our desk but as part of our mandate as a department." ... ISD also became part of the strategic planning for every involved ministry ...

Dr. Patricia Peterson, Presentation to the Committee, April 13 2015

We have privacy agreements, we have confidentiality agreements. It took a privacy impact report ... before we were able to overcome those issues, in the interest of the child. What it boiled down to is that if you have family consent, you're good to go ... The information-sharing and the privacy issues and going to the one-child, one file point was absolutely essential to this process but it was very complex to arrive there.

Dr. Patricia Peterson, Presentation to the Committee, April 13, 2015

Integrated Service Delivery in New Brunswick

The Committee learned of an inspiring example of service integration in New Brunswick. Drs. Patricia Peterson and Bill Morrison described the work they did for the New Brunswick Government to implement a new Integrated Service Delivery (ISD) framework for child and youth mental health. Four ministries and regional health authorities engaged in strategic planning for ISD which resulted in the delivery of their programs in a more coordinated manner.

One of many issues addressed in order to enable the significant shift to an integrated and child-centred model involved addressing privacy and consent issues to enable the necessary information-sharing between professionals working on the children's files.

Following completion of a privacy impact assessment, the model permitted information sharing among the ministries and regional health authorities. This enhanced the ability of clinicians, educators and other professionals to work together and deliver services in an efficacious and cost-effective way that served the best interests of the child. This "one child, one file" approach also made a significant difference in the experience of children, youth, and their families in accessing services.

While waitlists for services were a significant motivator for government in seeking a fundamentally new approach to child and youth mental health, Dr. Peterson reported that waitlists for services were "one of the quickest things to come off the list as a problem area," and "one of the easiest things to take care of when ISD was implemented." Waitlists, previously anywhere from six months to a year, were reduced to the range of no waitlist at all to about two weeks.

Reduced “attrition,” or missed appointments by youth, helped increase efficiency and reduce waitlists. Dr. Morrison noted that in working in community based mental health services, he often saw an attrition rate of 30% to 50%; that is, as many as half of all appointments were missed by youth. Offering services to youth where they are – in school – brought the attrition rate down to nearly 0%.

Drs. Peterson and Morrison also emphasized that the new model generally involved a rearrangement of resources and services rather than the addition of more funding or staff.

Building on existing system strengths and also actively addressing barriers to integration, such as “turf” protection by professionals in the system, a culture shift toward collaboration – rather than just “case conferencing” – has been achieved. Ultimately, in addition to better results for children and youth, the system also works better for clinicians.

In addition to capitalizing on schools as a primary location for service delivery, the model is remarkable in demonstrating the benefits of shared commitment and leadership. The government of New Brunswick openly sought a new model for serving children; commissioned expert advice on how to restructure the system; and through leadership at all levels -- elected officials, the public service (senior administrators), and clinicians and educators -- implemented an extremely promising model that is intended for expansion across New Brunswick.

What we found to the delight of our ministries was that it wasn't about a lot of extra money. It wasn't about creating new positions. These are the same service providers working with the same kids at risk and the same numbers, so let's come together and do it smarter. Although there was some financial restructuring involved in bringing these teams together and making sure that they had spaces in schools, and those sorts of things, to do the work that needed to be done, it was not a huge outlay in new positions to add on to a system that wasn't working. It was a different way of using the system resources that we already had.

Dr. Patricia Peterson, Presentation to the Committee, April 13, 2015

When the teams came together, there was a revisiting of all the wait-lists and wait times. That initial responding ... eliminated wait times completely throughout the opportunity ... within a ten-day period, you had youth responded to and involved in services ... What we saw is that the utilization of services ... the number of people, the number of children and youth and families that were seen by team members – doubled and tripled during that time. That's because we'd lost our attrition rates of getting to services. Now we're seeing two or three times more ... we're seeing more children at earlier points, hence making a difference.

Dr. Bill Morrison, Presentation to the Committee, April 13, 2015

If you ask the biggest challenge -- it's the paradigm shift. It's the paradigm shift on how we do business: whether we're going to remain as system-focused, turf-protection mandates, or we make the decision to return to a value that puts children at the centre, that values development and strength-focused approaches, where we build those through our relationships in our social settings and we refuse to see prevention and intervention as separate, where we have a fully integrated system where we are on the same team.

Dr. Bill Morrison, Presentation to the Committee, April 13, 2015

When you have a child having to retell a story and be, in fact, revictimized by having to retell their story over and over again, it is the system, then, that is victimizing that child because of its inability to work as a whole, inability to cross through our sectors, through our professions, through our departments and ministries in the best interest of the child.

Dr. Patricia Peterson, Presentation to the Committee, April 13, 2015

Headspace youth mental health program in Australia

In his presentation to the Committee, Dr. Steve Mathias discussed the Headspace program in Australia upon which he based his Inner City Youth Mental Health Program. He described the Headspace program as a nationally-funded network of youth-friendly “one-stop shops” for mental wellness and treatment of mental illness. Mental health, physical health, alcohol and other drug services, and vocational and educational support are co-located in one youth-friendly centre. The centres are youth-friendly because of youth participation in the design of the centres and strong community and school connections. They also have a strong cultural connection to the Aboriginal population in Australia as well as special programs for LGBTQ youth. There are approximately 77 centres across Australia, including rural sites. Each centre has access to a centralized data collection and reporting service. There is also eHeadspace, which provides on-line access to real time chat lines and a live counsellor. Headspace has strong brand name recognition and social media presence and there is a high level of satisfaction with the program.

The Committee was impressed with these examples of integrated hubs that exist in BC and in other jurisdictions for the delivery of mental health and social services to children and youth. They helped to inform the Committee’s vision for the delivery of child and youth mental health services in this province and underpin the Committee’s recommendations.

We all have an idea of what needs to be done, but we have not had the proper structure or mechanism to effectively implement the solutions or the strategies that have been mentioned. The focus needs to change from the capacity of the system to the child ... Not only is this suggestion an opportunity to create efficiencies over time; it's also the right thing to do for our children.

Chief Officer Neil Dubord, BC Transit Police and Delta Police, Presentation to the Committee, June 23, 2015

Conclusions

The Committee has spent the past two years listening to parents, youth, mental health professionals, and community service providers sharing their experiences about the support provided by existing programs as well as their frustrations with gaps in child and youth mental health, cognitive disability, and addiction services.

One consistent message the Committee heard is that it is critical that urgent action be taken to improve the delivery of mental health services to children, youth, and young adults. We know the current level of mental health services in British Columbia is not meeting the demand for child and youth mental health services. While we have many services available, they are not necessarily easily accessible or well integrated as a system of care. We have heard the urgent need to address the challenges faced by children, youth, their caregivers, and mental health professionals.

We know there is a clear impact when assessment and treatment of mental illness in children and youth are delayed. Acting now to improve mental health services could reduce the consequences of mental illness in our youth population and its impact on the economy and society. Action is especially critical in regard to vulnerable populations, including children in care and Aboriginal children and youth. Without reform of mental health services to children and youth in British Columbia, we will face increased costs to our health care system, increased interactions between youth and law enforcement, more difficulties in the classroom, and

lost potential economic contributions to society because of under employable or unemployable young adults.

The Committee urges that its recommendations for concrete actions to improve child and youth mental health services be undertaken by government as a matter of high priority.

Leadership and Accountability

The Committee shared the view of presenters that strengthening service delivery across the network of children and youth programs depends on leadership and accountability. In that regard, the Committee considered the input it received on the question of whether Child and Youth Mental Health Services should be transferred from the Ministry of Children and Family Development to the Ministry of Health. After reviewing the evidence on this matter, the Committee unanimously agreed on a different solution.

The Committee recommends that a new Cabinet Minister be appointed to assume responsibility for the funding and coordination of mental health services in the province. In the Committee's view, it is time for mental health to be given the profile and attention that it deserves and a new and separate Cabinet level portfolio for mental health services would help to achieve that objective. The Committee believes that a new Minister for Mental Health devoted to improving the cross-ministry delivery of mental health services would result in strong leadership and accountability in this area. It would provide a focal point for ensuring the coordination and effectiveness of services. In addition, it would send a strong signal that preventing and treating mental illness are priorities for government. It may also contribute to

We get so mired in our systems that too often our ministries, our systems, our comfort zones and our turf are protected over and above the needs of the child or the youth. What we were asked to do is to put all assumptions aside and design something that was child- and youth-focused ... Sometimes we need to go back, take a step back and think universally. It's not just about kids at risk. It's about avoiding the intensity of risk that can exist, by starting earlier with our kids ... The goal, as well, was to reduce the prevalence of those kids with complex needs, to keep them from working their way up through the pyramid of interventions so that they don't get noticed until they're in that top 5 percent. What do we do with the whole pyramid? How do we integrate that wellness platform for our kids in the school setting?

Dr. Patricia Peterson, Presentation to the Committee, April 13, 2015

lessening the stigma of mental illness because the Minister will be able to stimulate more public discourse about the fundamental importance of promoting mental wellness and providing treatment for mental illness.

This recommendation aligns with a recommendation made in the past by the Representative for Children and Youth. Her recommendation was that a new Minister of State for Youth Mental Health be created to establish a single point of accountability for addressing the needs of transition-age youth (ages 16 to 24) with mental health problems and the related services that span across ministries and service delivery areas. The Committee's recommendation would broaden the portfolio to include responsibility for services to children and youth and would ensure that a Minister (rather than a Minister of State) would have the authority to administer a budget for the funding of services. The Committee's recommendation also aligns with dedicated Ministers for Mental Health that exist in other jurisdictions, including in the Australian state governments of Western Australia and Victoria.

Too often YES youth and volunteers have heard about funding for youth initiatives that does not require collaboration, and that goes to support single focused services that benefit only a select group of pre-identified young people ... YES would like to see funding opportunities ... that reward integrated service ... and that target the well-being of all youth.

Amberlee Erdmann, Youth Engagement Strategy, Written Submission

With a budget and formal responsibility for child and youth mental health services, the Minister for Mental Health would engage in strategic planning with partner ministries and health authorities and fund the delivery of services. Services to children, youth, and young adults range from mental wellness initiatives that build awareness and reduce stigma, to community and school-based early intervention, clinical services, and social services, and to acute care for the most severely ill by health authorities in hospital settings. The Minister for Mental Health would ensure that this wide range of services is integrated and funded under the integrated model and also coordinate the delivery of these services across government, involving the Ministries of Health, Children and Family Development, Education, Advanced Education, Social

Development and Social Innovation, Jobs, Tourism and Skills Training and Minister Responsible for Labour, and BC Housing, amongst others.

Each of the models in BC discussed –Mountainside Secondary, the Cariboo Action Team, and Inner City Youth Mental Health – utilized two or more ministries in some capacity. The Minister for Mental Health would ensure that services are integrated and coordinated on a cross-ministry basis and are funded appropriately.

Coordinating a wide range of services and programs would result in greater transparency and accessibility and align accountability and responsibility for child and youth mental health services with one Minister. That new Minister should also have the mandate to work with the federal government on the delivery of services to First Nations children and youth on and off reserve.

With respect to services for children and youth, the objective should be a collaborative, multi-disciplinary, integrated approach to providing and enhancing a full spectrum of child and youth mental health services. There is also an opportunity for the Minister to focus specifically on the unique needs of transition-age youth and young adults and develop a plan for this age cohort.

The Minister for Mental Health should be accountable for improving the delivery of mental health services to children, youth, and young adults, including setting meaningful performance measures and reporting on results in an open and transparent manner.

Recommendation

The Committee recommends to the Legislative Assembly that the provincial government:

1. Assign responsibility for leadership and the coordination of child and youth mental health services to a new Minister for Mental Health.
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Integration and Delivery of Services

The Committee sees a significant opportunity for the new Minister for Mental Health to turn a fragmented network of services into something that can rightfully be called a child and youth mental health system. The objective should be a collaborative, multi-disciplinary, integrated approach to providing and enhancing a full spectrum of child and youth mental health services.

The Committee's second core recommendation is for an integrated service delivery model. The Committee considers that many of the most promising solutions for improving child and youth mental health are those that integrate and coordinate services. This should be a foundational design principle for the child and youth mental health system.

The Committee believes that an integrated service delivery model is a key systemic change that will result in meaningful, lasting progress toward a system that supports children and youth living with mental illness. A Minister for Mental Health should have an explicit mandate to direct funding towards those initiatives that have a collaborative, multi-disciplinary, and branded integrated approach.

This may not entail additional funding beyond what is already being spent. Many of the Committee's specific, targeted recommendations could be implemented immediately and without additional funding. Taking these steps would provide evidence that integrated, coordinated approaches are more effective in terms of results and costs.

School-based hubs

Our schools are important sites for the development of children. The Committee believes that there should be school-based hubs in all school districts. This would greatly enhance the delivery of mental health services to children and youth.

Laurie Birnie from the BC School Centred Mental Health Coalition identified the following four strategic priorities to build school connectedness: student and family

engagement around mental health and wellness; building school system capacity for mental health and wellness; building those partnerships with those that serve our families and our systems around that need; and to take a look at the policies and practices that guide our practice and what we do with children in schools.

Educators are well positioned to observe emerging behavioural disorders and symptoms of mental illness. Children may display behaviors indicating stress with the demands of education, bullying, or a difficult family life. They may also be experiencing physical, sexual, or emotional abuse. Schools are an environment where stigmatization of youth happens on a daily basis.

Given the many expectations already placed on educators, we must be careful not to add to their role beyond their potential to be early identifiers of mental health issues and be positive role models on mental wellness.

When parents and teachers realize that a child is encountering learning difficulties and there are noticeable behavioural changes in a child or youth, it should not take months or a year to have an assessment and strategies put in place to address needs without harmful labeling. Fully funded child psychologists made widely available in school districts would significantly improve the availability of early intervention.

As the Committee heard from Dr. Wilma Arruda regarding the project to provide health care services in a wellness centre at John Barsby Community School in Nanaimo, “school-based health centres exist at the intersection of education and health and are the caulk that prevents children and adolescents from falling through the cracks.” Moreover, school-based hubs are child- and youth-friendly as they deliver services where children and youth spend much of their time. School-based hubs such as Mountainside offer a “one-stop shop” that facilitates access to services.

Community-based hubs

The other model that merits expansion is community mental health centres for youth that provide a range of services for youth with multiple needs, including social services such as housing and employment. The Committee endorses the recommendation of Dr. Steve Mathias to create community integrated youth health

and social service centres in all areas of the province. Similar to the Headspace program implemented across Australia, these centres would provide an integrated approach in responding to the primary care needs of youth along with primary mental health and substance abuse care, employment supports, and linkages to other social and justice system services for youth. This holistic approach would support recovery and community reintegration.

These youth-friendly centres would more effectively utilize and integrate existing programs and services through a “one-stop” location that includes primary care physicians, nurse practitioners, psychologists, addictions counsellors, mental health social workers, and employment advisors. These centres could provide mental health and addiction assessments along with physical health care and social work services for adolescent youth in transition. They could be structured to allow access for youth and young adults up to age 25.

A multi-year pilot project approach could be used to quickly launch new school- and community-based hubs. Lessons learned from the pilot projects would provide a basis for expanding these models across the province.

Recommendation

The Committee recommends to the Legislative Assembly that the provincial government:

2. Make multi-year funding available for existing integrated service delivery programs in British Columbia; initiate multi-year pilot projects that would establish more integrated, collaborative, and multi-disciplinary school- and community-based “hub” site approaches to the delivery of mental wellness programs and clinical and social services to children, youth, and young adults; and provide targeted funding that rewards integrated services.
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Removing barriers to effective service integration

To enable meaningful integration and coordination of service delivery, some specific barriers need to be addressed.

Legal barriers to information sharing by professionals caring for children and youth (e.g., teachers and school counsellors, doctors, counsellors, psychiatrists, and others) were frequently cited in submissions to the Committee as a barrier to providing effective, coordinated services. Some family members also felt that legal barriers, or at least the perception of legal barriers, prevent families from being adequately involved in treatment, particularly of adolescents who may state that they do not want their families to know they are seeking services.

Some of these barriers around information sharing are likely exacerbated by the divided responsibilities for different components of child and youth mental health services. An integrated system would foster a “one file, one child” philosophy.

Information and data

The Committee also heard that due to issues such as the fragmentation of services across ministries, use of private providers (such as counsellors paid for by families), information not being made available because of legal and professional obligations (and possibly misunderstandings about the relevant privacy legislation), and technological limitations, there is not enough data and information on basic issues such as the number of children receiving services relative to the number needing services and waitlist lengths. Better information would result in better system planning and investment.

I think if there was a policy developed or there was an MOU at the highest levels of government, amongst the ministries, and that policy is cemented on information-sharing, it would add so much more credibility and confidence to the actual practitioners in the field.

Inspector Barb Vincent, Crime Prevention Services, RCMP “E” Division, Presentation to the Committee, June 24, 2015

I saw a youth in the hospital just a couple of weeks ago. I’m trying to follow them up now in the clinic at the MCFD office. When I do that ... I request the records, and they say: “Sorry. They were supposed to sign those at the hospital before they came, so they can’t come.” We say ... “We need them here anyway. They’re my records. I dictated them.” “Sorry. We can’t do that.”... Then I go back for ... a follow-up, and ... it still hasn’t happened.

Dr. David Smith, Presentation to the Committee, June 24, 2015

The July 2015 Joint Ministry Submission noted that while 28,000 individuals received child and youth mental health services in 2014/15, a recent research study from Simon Fraser University suggests that “approximately 69% of children and youth with a mental disorder do not receive the specialized, multi-disciplinary mental health services they need.” However, the Ministry submission also noted “some of the 69% may access service through their family physician, emergency room, school counsellor or community agency or private practice psychologist or counsellor. Currently we are not able to determine the number of children and youth accessing these other services, details about the type of services provided or the outcomes achieved.”

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

3. Foster a “one child, one file” philosophy and address real or perceived barriers to information sharing among care providers.
 4. Make investments in information technology to facilitate information sharing and data collection that would enable better system planning and service delivery.
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Timeliness of service delivery

The Committee heard that delays in treatment and waitlists are a significant concern. The Joint Ministry Submission to the Committee acknowledged that challenges include gaps in service availability and lengthy waits for some services.

The Committee considered that long waitlists could be remedied, at least in part, by government setting clear expectations and delivery targets in a policy directive to ministries. This policy directive would require that all children and youth identified as exhibiting signs of behavioural, emotional, or mental health issues be assessed within 30 days and begin receiving treatment within the next 30 days.

These targets would help drive improvements in the delivery of mental health services. The Committee expects that ministries will either reallocate existing resources to achieve these targets or demonstrate the need for additional funding to achieve them.

Recommendation

The Committee recommends to the Legislative Assembly that the provincial government:

5. Establish targets to ensure that children, youth, and young adults identified as exhibiting signs of behavioural, emotional, or mental health issues are assessed within 30 days and begin receiving treatment within the next 30 days.
-

Every child wants to contribute. Every child wants to learn. Every child wants to be great. Every child wants to be connected. A child that's disconnected might deny that. Teachers might not believe it. But it's an undeniable truth of their biology that every kid wants to be connected, and they need to be connected.

Bill Adair, Presentation to the Committee, June 24, 2015

It would be really great to have someone you can talk to and go to without feeling the stigma of talking to a professional or walking into the counsellor's office.

Mia McBryde, Video Submission

Just a place to go where we can talk about these issues. If everyone's talking about it, it breaks the stigma about mental health and people that deal with these issues being more comfortable talking about them in the long run ... If we had an advocate for mental health in our school... who could talk to kids who are dealing with these problems and making sure this is all done more informally.

Victoria Ritchie, Video Submission

I think that what we need to focus on is peer-to-peer support, informal support ... we need people to talk about it more to reduce the stigma. So one of the things that would be great to reduce the stigma would be an engagement worker that goes around to the schools and familiarizes people with mental health... and creates a relaxed and informal setting to talk to people about mental health, whether they need help or just want to learn more about it.

Jaida Smith, Video Submission

Child- and youth-friendly services

As a general principle of service delivery, the voices of those who need to use the services should be a primary consideration. It is likely that services designed with leadership and participation by youth are more likely to be used by youth. The Committee heard some excellent examples of youth-led initiatives, such as Brent Seal's Edge program. As a young adult with lived experience of mental illness, he designed a program for delivery in schools that is intended to provide mental wellness education in a fun and non-stigmatizing way, benefitting anyone who participates, but particularly those who may be experiencing mental health issues. Another interesting innovation has been developed by Aidan Scott, the founder of SpeakBOX, which is a proposed web-based mental health treatment and support model that would supplement existing psychotherapies with self-led, web-based equivalents to increase patient capacity, cost effectiveness, and provide faster access to treatment.

Submissions from youth involved in Penticton's Youth Engagement Strategy illustrated youth's preferences in terms of accessing mental health. Informal, non-stigmatizing ways of accessing information and assistance are clearly important to youth, as is peer-to-peer support. Submissions from youth emphasized that youth do not see a clear dividing line between services that provide important protective factors, and services for mental health treatment/intervention; generally, they said that a spectrum of information and help should be available in one place where youth feel comfortable.

The Committee agrees that some of the best opportunities to build awareness of mental wellness and reduce stigma involve children and youth, both as an audience of the messages and originators of the messages. Opportunities to incorporate children, youth and families into service design and delivery should also be sought. A

good model for this is the Matsqui-Abbotsford Impact Society/ Valley Youth Partnership for Engagement and Respect. It is an example of an innovative organizational model that is designed to support strong youth participation and leadership in designing programs and services to meet youth needs.

Some submissions to the Committee noted that young males tend to be more reluctant to seek help for mental health issues. However, some promising results have been evident in using alternative approaches, such as technology-based strategies.

In addition to being youth-friendly, it should be recognized that different cultures may view mental illness differently. Certain cultures may also have historical contexts that need to be considered as they may relate to the prevalence of mental health problems, and to the most appropriate and effective approaches to promoting mental wellness for those communities. The legacy of trauma from colonization experienced by Aboriginal people is a particularly salient example in BC.

Recommendation

The Committee recommends to the Legislative Assembly that the provincial government:

6. Seek input from children, youth, and their families on the design and delivery of mental health services.
 7. Make investments in online mental health programs designed for youth and young adults.
 8. Use client satisfaction surveys to gather feedback from children, youth, and their families on their experiences with programs and service delivery.
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The lived experience of many young people is that adults neither listen nor learn ... When youth design the skateboard park, the park gets used and it brings the real "skater kids" into the relationship. When youth create the workshops about health and self-care, looking after your own well-being becomes a sensible idea to peers. ... Adults are typically in the privileged position of having a choice about how and even whether they engage with specific young people. Young people ... may never or rarely have this privilege with the adults in their lives. Instead, for a wide range of complex reasons, their opportunities may have boiled down to either taking what is offered how it is offered, or going without.

Matsqui-Abbotsford Impact Society/
VYPER, Written Submission

Types of Services

In addition to its key systemic recommendations on how services should be delivered, the Committee makes the following recommendations with respect to what services should be available in the child and youth mental health system. These are broadly described as:

- ✦ Mental wellness
- ✦ Early intervention
- ✦ Clinical services

The examples provided under each recommendation suggest specific actions that could be taken to improve these kinds of services.

Support for mental wellness

Universal or broad approaches that build protective factors against certain mental illnesses were a dominant theme in submissions to the Committee in the second phase of consultation. Early intervention when mental health issues begin to emerge was another theme. Common sense suggests that mental wellness and early intervention should be emphasized in child and youth mental health services; however, the large number of submissions emphasizing this point suggests that the need for “front end” investment in prevention and early intervention is not being implemented broadly enough or effectively enough.

Schools

The Committee considers that schools provide a natural context for offering broad/universal programs to build children’s resilience and coping skills, improve mental health literacy, and reduce

I know that the acute side of things is always going to get more attention, but I think government has an opportunity to say: “That’s important, but this bottom piece is just as important.” When someone shows up talking about suicide, things happen for that young person. There’s no question about that. Is it always enough? Maybe not. But when a kid shows up at school disconnected or feeling unregulated, is there attention for them? Lots of times there isn’t — until it rises to the level of: “You’re interrupting everybody else, so now we’re going to deal with you.” Well, what about the kid before it got to that place? We need to look at that.

Dave Mackenzie, BC School Centred Mental Health Coalition, Presentation to the Committee, June 23, 2015

stigma. Laurie Birnie of the BC School Centred Mental Health Coalition told the Committee that, “next to the family, school connectedness is the most defined protective factor in a young person’s life.” Many submissions emphasized the importance of a healthy school environment in promoting positive mental health, and that connectedness is key to a healthy school environment.

Many submissions also noted that mental health problems are sometimes first evident in school; as such, early intervention could happen in school. Yet schools are an under-used – or at least inconsistently-used -- setting for mental health promotion and intervention. Innovative programs exist in this area and could be expanded to promote mental wellness and early intervention (e.g., FRIENDS).

It may also be time to take steps to provide mandatory mental health education in schools for children and youth similar to what is provided in relation to sexuality. Youth should leave school knowing what contributes to good mental health and how to develop their own mental well-being, ways to handle stress, and how to support friends and family members who are experiencing emotional or mental difficulties in their lives, as well as how to seek help for themselves and others when it is needed.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

9. Support connectedness initiatives in schools and expand existing school-based programs that are proven effective for promoting children’s resiliency (e.g., FRIENDS).
 10. Make mental health education in schools mandatory.
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While it is generally accepted that “an ounce of prevention is worth a pound of cure,” it may not be surprising that resources, particularly in periods of financial austerity, have tended to flow easier toward acute conditions that can be very concretely addressed with measurable results (even if not always statistically significant) than toward preventing acute conditions – where so many questions still exist.

Matsqui-Abbotsford Impact Society/
VYPER, Written Submission

We do spend money now that isn’t effective, for example, on inappropriate physician prescribing, using the wrong medications that actually cause harm to kids while not providing these effective psychosocial interventions, or providing psychosocial interventions that aren’t in this category — well tested and known to be effective.

Dr. Charlotte Waddell, Presentation to the Committee, June 23, 2015

Support for early intervention

The Committee received evidence to support the concept of early intervention in mental health issues. That said, it is difficult to prioritize system resources towards early intervention due, perhaps, to limitations around available data. However difficult it might be to quantify the value of prevention and early intervention overall and across systems, specific programs are increasingly working to demonstrate their costs and benefits (including in terms of saved resources) as part of their evaluations. The FRIENDS program is an evidence-based school-based anxiety prevention and resilience program funded by the Ministry of Children and Family Development. The “Stop Now and Plan” (SNAP) program provides cognitive behavioral therapy to children aged six to eleven with serious disruptive behavior problems. In its submission, the Child Development Institute indicated that the SNAP program is free to participating families and costs approximately \$4,000 for a child and his/her family. The Child Development Institute stated that without the intervention of the SNAP program, “the very plausible alternative of progressing to incarceration would cost society \$1.5 to \$2.5 million per child in custody, policing, probation, health and victim costs for male offenders between the ages of 12 and 21.”

By creating the conditions that support the process of resilience, the incidence and prevalence of mental health problems is reduced, while at the same time severity of problems like depression and anxiety are reduced and recovery rates are enhanced.

Matsqui-Abbotsford Impact Society/
VYPER, Written Submission

As noted earlier, Dr. Charlotte Waddell, in her presentation to the Committee, noted that the “Nurse-Family Partnership,” an early intervention program (prenatal to age two) aimed at preventing child maltreatment, saves an estimated \$18,000 per family through reduced public spending over 10-15 years (e.g., reduced healthcare, social assistance, child protection and justice costs). The Committee was very pleased to learn of programs such as these that demonstrate improved outcomes for children and youth in the near term, as well as downstream savings of this magnitude.

The Select Standing Committee on Finance and Government Services recently recommended in its report on the Budget 2016 consultations that the provincial government ensure that a coordinated, effective and responsive system is in place for children and youth who face mental health challenges, including early intervention strategies. Its recommendation was based on submissions it received from several organizations on the importance of early intervention in a healthy living strategy to ensure timely and coordinated mental health services and supports for children and youth.

Early intervention includes programs to identify children and youth at a risk of (or currently experiencing) mental illness that could escalate into violence. Submissions from the family of Kimberly Proctor, a young woman murdered by two students at her school in 2010, emphasized the general principle of early intervention, and cited a number of specific programs in place in schools that should be broadened, such as Expect Respect, and a Safe Education (ERASE) and the Threat Assessment Protocols (Provincial Guidelines for Violence Risk Assessment). They also emphasized mandatory, court-ordered treatment for offenders in the interests of public safety.

With many families affected by system failure, current funding constraints, ignorance, and stigma, our programs, designed for and offered by families, at no charge and in a welcoming space, provides a viable, affordable solution.

North Shore Schizophrenia Society,
Written Submission

Community service providers

The Committee received a number of submissions from community service providers regarding their early intervention programs.

In some cases, the service provider did not have an explicit mandate to provide mental health services, but the agency's clients or program users would be more likely to have mental health issues due to the vulnerable nature of the population served by the agency (substance users, children in care of government, LGBTQ youth, etc.).

In other cases, the service provider had a broad mandate to provide connections to the community, life skills, recreational opportunities, and other protective factors against mental illness.

As examples, the Matsqui-Abbotsford Impact Society's "Valley Youth Partnership for Engagement and Respect" (VYPER) initiative is funded by the Health Canada Drug Strategy Community Initiatives Fund, but frequently works with youth with mental illness. A belief in the broad protective value of resilience, youth leadership and collaborative approaches underpins VYPER's approach to its funded mandate. In describing its mentoring services, Big Brothers Big Sisters (Prince George branch) noted that, "caring adults provide young people with a sense of belonging, acceptance, empowerment and connection, factors that are known to foster mental health and emotional well-being," and that the children, youth and families the organization typically serves may have a number of vulnerabilities connected to poor mental wellness, such as poverty.

These types of community service providers play a crucial role in mental wellness, even if they are not explicitly recognized for this role.

We need to stop talking about Youth Mental Health issues and put measures in place for early detection and treatment. It is a fact the prevention is more cost effective than non treatment.

Linda Proctor and Jo-Anne Landolt,
Written Submission

Additionally, there are a significant number of non-profit organizations that build awareness of mental illness (sometimes focusing on specific disorders), advocate for people with mental illness, and are often involved in providing support services to families. Their role in mental health should be acknowledged, and specifically, their work to support families to better cope with loved ones' illnesses, navigate services, and assist family members to engage in self-care should be supported.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

11. Provide funding for adequate early intervention programs for common and preventable disorders in children, including partnerships with non-profit organizations and the philanthropic community.
 12. Make parent training and cognitive behavioural therapy support services available.
-

We need to treat anxiety/depression as we would treat any other form of aggressive disease. With aggressive, immediate treatment. To follow through with this we need accessible treatment options available. Now. Not in another two, three, four, five years. We need options for every community.

Tricia Highley, Chloe Grace Foundation, Written Submission

There needs to be more consistency between health regions for treatment access. We live five minutes east of Boundary Road, so therefore cannot access Coastal or Providence programs such as the Inner City Youth program. We have been advised to either lie about our address, or encourage our son to live for a while in the Downtown Eastside so that he can access programs that don't exist in Fraser Health.

Mae Burrows, Written Submission

Ensuring adequate, appropriate clinical services are available

Overall, services were frequently reported as difficult to access or not youth and family friendly. Barriers to accessing services, such as health authority service boundaries, were often difficult to understand and frustrating to families. Collaboration between health authorities and other health care providers may be weak. There is a need to develop stronger linkages between health authorities and between health authorities and other health care providers.

Service effectiveness could be strengthened by better psychiatric care, especially in emergency departments. Registered psychiatric nurses need to be more broadly employed to improve the quality of first contact care.

There is also a need for clear and appropriate discharge plans for children, youth, and young adults leaving inpatient mental health services as they enter outpatient follow-up care.

Alternatives to emergency departments should be considered. Assertive Community Treatment teams are offered in most BC urban communities and are a proven resource for responding to adult mental illness acute episodes. This concept could be the basis for a similar approach for youth in a mental health crisis. Assertive Youth Treatment teams could respond to youth in crisis with severe acute mental illness episodes.

The Committee heard about health human resource challenges such as a shortage of child and adolescent psychiatrists. This results in long wait lists for services and is an issue that needs to be addressed as part of a long-term strategy to improve mental health services. More training opportunities to increase the number of

these specialized professionals would improve child and youth mental health services.

The use of technology such as telehealth can increase the number of patients who are able to receive treatment from specialists such as child and adolescent psychiatrists. This would improve the availability of assessments and treatments for children, youth, and young adults in rural and remote areas.

Funding for psychologists also needs to be a priority. The College of Psychologists has approximately 1200 members. These are primarily PhD university trained mental health professionals. Given the demand for competent mental health practitioners, it is time to develop a funding mechanism to integrate psychologists into the child and youth mental health system. Other provinces have found a way to use psychologists to address the mental health needs of their population. A BC strategy to use psychologists could improve access to assessment and treatment planning for children, youth, and their caregivers.

Over two-thirds of the kids with disorders aren't receiving needed services. That's about 58,000 a year in British Columbia. Prevention programs ... could do a great deal to reduce those numbers, but we don't fund a whole lot of those either. These shortfalls we do not tolerate for childhood cancer or diabetes. We treat 100 percent, and these shortfalls shouldn't be tolerated any longer for kids' mental health problems.

Dr. Charlotte Waddell, Presentation to the Committee, June 23, 2015

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

13. Develop stronger linkages between health authorities and between health authorities and other health care providers.
14. Improve the quality of first contact in emergency departments by employing registered psychiatric nurses more broadly and ensuring proper discharge planning to outpatient follow-up care.

At MCFD we have a child and adolescent psychiatrist for every 11,000 children. The standard is for every 4,000. We have a significant deficit in child and adolescent psychiatrists. We're not graduating enough, and the funding for the fellowships for child and adolescent psychiatry is annual, year to year. They're not guaranteed year to year. So they vacillate between three and four on an annual basis, and they do not have long-term funding.

Dr. Steve Mathias, Presentation to the Committee, June 11, 2014

15. Establish alternatives to emergency departments for urgent/acute psychiatric care such as Assertive Youth Treatment teams.
 16. Ensure adequate support and training of child and adolescent psychiatrists.
 17. Strengthen services delivered by psychologists to children, youth, and young adults through public funding.
 18. Expand the delivery of clinical services to rural and remote areas through the use of technology such as telehealth.
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Services to Vulnerable Populations

Transition-aged youth and young adults

The Committee is concerned with the needs of all children and youth, and believes there is a strong rationale for an increased focus on youth and young adults. The needs of this latter group and the manner in which they receive services demonstrate how child and youth mental health requires governance changes and better service integration. It is a strong example of services being designed with the various service arrangements -- not the needs of youth and best evidence around treatment -- as the primary organizing principle.

The Committee heard that the peak of mental health issues occurs between the ages 14 and 25. From a population health perspective alone, there are strong arguments for special treatment of this age cohort. It is also a time of increasing social and legal recognition of youth's rights to – and expectations of – greater decision making and autonomy, regardless of whether youth are well-equipped to navigate the adult world. Midway through this age span, at age 19, youth are no longer eligible for child and youth mental health services.

Submissions to the Committee suggested options for achieving better treatment for transition-aged youth and young adults, such as:

- Increased funding for transition-planning services and generally better communication across youth and adult-serving systems; and
- Extending eligibility for child and youth mental health services to an older age, such as 24 or 25.

We shouldn't be focusing on transitioning kids to adult services. We should be focused on transitioning kids to community and reintegration and psychosocial rehabilitation and focusing on cognitive learning disabilities and severe illness and making sure that these kids don't fall through the cracks and end up on our streets.

Dr. Steve Mathias, Presentation to the Committee, June 11, 2014

Adult mental health services are... designed for chronically ill individuals — average age of 40 to 45 — and we're asking young people to access adult mental health services when they graduate from child services. We keep talking about not having transition protocols or being able to transition young people from child services to adult services properly. That's not the issue. The issue is that we're... asking them to access and use services that are not designed for them.

Dr. Steve Mathias, Presentation to the Committee, June 11, 2014

The Committee considers that better serving transition-aged youth and young adults is a core, systemic re-alignment needed to make meaningful and lasting improvement. Young adults with mental illness, cognitive disabilities and addiction issues need responsive services to help them navigate the transition to responsible, mature adult living. Maintaining access and continuity of benefits and services after age 18 could improve outcomes for these young people and make them more employable, mature contributors to society.

The Committee also agrees that the goal of any changes to how services are designed for transition-aged youth and young adults should be recovery and reintegration into the community, rather than simply smoothing a transition into an adult system.

A new Minister for Mental Health would provide an opportunity to focus on the unique needs of transition-aged youth and young adults and develop a plan for this age cohort.

Recommendation

The Committee recommends to the Legislative Assembly that the provincial government:

19. Develop and implement a specific plan for transition-aged youth and young adults in order to ensure that services to this age cohort are included in the integrated service delivery model.
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Aboriginal children and youth

The Ministry of Children and Family Development reported that while Aboriginal children and youth are over-represented in some systems of care (e.g., youth in care), they may be “under-represented in mainstream mental health services,” and that “suicide rates among Aboriginal youth aged 10 to 29 in Canada are estimated to be five to seven times higher than youth in the general population.” Submissions to the Committee from the Office of the Provincial Health Officer and the BC Association of Aboriginal Friendship Centres noted the unique mental health needs of on and off reserve First Nations people, such as the intergenerational impacts of trauma caused by residential schools.

The Committee also heard that the particular governance arrangements affecting service provision (e.g., federal responsibility for Aboriginal people on-reserve; provincial responsibility for health and child welfare) add complexity to effectively delivering services in respect of the significant unmet need for better – and culturally safe – mental wellness programs and treatment of mental illness. The Committee was interested to learn of significant strides being made by Aboriginal health organizations such as the First Nations Health Council and First Nations Health Authority in improving services for Aboriginal youth, but remains concerned that a focus on Aboriginal children and youth be part of any child and youth mental health system and service plans.

There are a few programs in BC that are designed to meet the needs of Aboriginal youth. The Committee heard that “Aboriginal knowledge is personal, oral, experiential, holistic, and conveyed in narrative or metaphorical language.” Deb Abma from the Focus Foundation stated that “Among the most vulnerable subset of youth in British Columbia addressing mental health requires a development of integrated and evidence-based models that are culturally relevant to and restorative for diverse aboriginal youth.” Kathreen Riel spoke to the Committee about the WITS program which she described as having three goals – to prevent or reduce bullying and peer victimization, to promote pro-social behaviours, and to create responsive communities. She noted that “There is a good fit between the WITS program and aboriginal communities because we use the structure of sharing stories.

This is a good fit for many of those traditions in which the sharing of stories helps to model appropriate behaviours and values.”

The Committee was of the view that more of these culturally appropriate programs should be delivered to Aboriginal children and youth. It would be beneficial for the provincial government to expand its efforts to work with the Federal Government on mental health and addictions of First Nations youth to specifically target that population on and off reserve and ensure a full range of culturally appropriate mental health services is available to them.

Recommendation

The Committee recommends to the Legislative Assembly that the provincial government:

20. Make culturally appropriate programs for Aboriginal children, youth, and young adults a priority for child and youth mental health services.
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Sexual and gender minority youth

In a brief submitted to the Committee, Dr. Kristopher Wells of the Institute for Sexual Minority Studies and Services at the University of Alberta indicated that estimates are that out of 633,428 BC students registered in schools in 2014/15, around 50,674 would identify as LGTBQ or questioning. That is a substantial number of students, and considering that an estimated 27% of LGTBQ students were threatened with violence at school (compared with only 13% of heterosexual students), it is perhaps not surprising that LGTBQ youth are more likely to experience mental illness than heterosexual youth.

Vancouver Coastal Health's Transgender Health Information Program (THiP) estimated there are about 12,000 trans (transgender, gender non-conforming, gender diverse, gender creative, etc.) children and youth in BC (including young adults up to age 24). THiP's submission noted a severe lack of services tailored to trans students in any area of the province and cited a study based on a survey that found that 74% of trans youth are verbally harassed about their gender expression, and 78% of trans students felt unsafe at school.

Schools need to support their sexual and gender minority students through initiatives such as stand alone sexual identity and gender identity policies in school and support for gay-straight alliances.

Recommendation

The Committee recommends to the Legislative Assembly that the provincial government:

21. Require school districts to support sexual and gender minority youth in schools through general and targeted programs to address child and youth mental health issues.
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Children in care

The BC Federation of Youth in Care noted in its first phase submission to the Committee that there are about 8,000 children and youth in care, with about 4,400 of them being Aboriginal, in any given year in BC. The Federation reported that 65% are diagnosed with a mental health issue before turning 19. The July 2015 Joint Ministry submission reported study results indicating that psychiatric disorders in children and youth aged 0-18 in foster care range from 32% to 44%.

Given the adversity faced by children in care, and the alarmingly poor results on other outcomes (e.g., the Federation reports that 67% of youth in care “age out” without a high school diploma), it is clear that the mental health needs of this population must be prioritized.

Recommendation

The Committee recommends to the Legislative Assembly that the provincial government:

22. Provide all children in care with access to mental wellness programs, early intervention, and clinical services.
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Special needs children and youth

There are a number of other special populations that submissions to the Committee highlighted, such as children, youth, and young adults with concurrent disorders (mental health problems and substance use); those with dual diagnoses (mental health problems and developmental disabilities); those involved in the justice and forensics systems; those with parents with mental illness; and those experiencing complex mental health and/or substance use issues (e.g., multiple, serious, and co-existing problems).

Recommendation

The Committee recommends to the Legislative Assembly that the provincial government:

23. Make children, youth, and young adults with special needs a priority in child and youth mental health services, and integrate these needs in work on the redesign and strengthening of services.
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Summary of Recommendations

The Select Standing Committee on Children and Youth recommends to the Legislative Assembly that the provincial government:

Leadership and Accountability

1. Assign responsibility for leadership and the coordination of child and youth mental health services to a new Minister for Mental Health;

Integration and Delivery of Services

2. Make multi-year funding available for existing integrated service delivery programs in British Columbia; initiate multi-year pilot projects that would establish more integrated, collaborative, and multi-disciplinary school- and community-based “hub” site approaches to the delivery of mental wellness programs and clinical and social services to children, youth, and young adults; and provide targeted funding that rewards integrated services.
3. Foster a “one child, one file” philosophy and address real or perceived barriers to information sharing among care providers;
4. Make investments in information technology to facilitate information sharing and data collection that would enable better system planning and service delivery;
5. Establish targets to ensure that children, youth, and young adults identified as exhibiting signs of behavioural, emotional, or mental health issues are assessed within 30 days and begin receiving treatment within the next 30 days;

6. Seek input from children, youth, and their families on the design and delivery of mental health services;
7. Make investments in online mental health programs designed for youth and young adults;
8. Use client satisfaction surveys to gather feedback from children, youth, and their families on their experiences with programs and service delivery;

Types of Services

9. Support connectedness initiatives in schools and expand existing school-based programs that are proven effective for promoting children's resiliency (e.g., FRIENDS);
10. Make mental health education in schools mandatory;
11. Provide funding for adequate early intervention programs for common and preventable disorders in children, including partnerships with non-profit organizations and the philanthropic community;
12. Make parent training and cognitive behavioural therapy support services available;
13. Develop stronger linkages between health authorities and between health authorities and other health care providers;
14. Improve the quality of first contact in emergency departments by employing registered psychiatric nurses more broadly and ensuring proper discharge planning to outpatient follow-up care;
15. Establish alternatives to emergency departments for urgent/acute psychiatric care such as Assertive Youth Treatment teams;
16. Ensure adequate support and training of child and adolescent psychiatrists;

17. Strengthen services delivered by psychologists to children, youth, and young adults through public funding;
18. Expand the delivery of clinical services to rural and remote areas through technology such as telehealth;
19. Develop and implement a specific plan for transition-age youth and young adults in order to ensure that services to this age cohort are included in the integrated service delivery model;
20. Make culturally appropriate programs for Aboriginal children, youth, and young adults a priority for child and youth mental health services;
21. Require school districts to support sexual and gender minority youth in schools through general and targeted programs to address child and youth mental health issues;
22. Provide all children in care with access to mental wellness programs, early intervention, and clinical services; and
23. Make children, youth, and young adults with special needs a priority in child and youth mental health services, and integrate these needs in work on the redesign and strengthening of services.

Appendix A: Public Hearing Witnesses

The Answer Model, Todd Ritchey, Bill Adair (2015-Jun-24, Vancouver)

B.C. Pediatric Society, Dr. Wilma Arruda (2015-Jun-24, Vancouver)

B.C. Psychiatric Association, Dr. Carol-Ann Saari, Dr. Matthew Chow, Dr. David Smith (2015-Jun-24, Vancouver)

B.C. RCMP “E” Division, Staff Sergeant Tom Norton, Inspector Barb Vincent (2015-Jun-24, Vancouver)

BC School Centred Mental Health Coalition, Laurie Birnie, Dave McKenzie, Deborah Garrity (2015-Jun-23, Vancouver)

BC Transit Police, Delta Police, Neil Dubord, Melissa Grannum, Delta Police (2015-Jun-23, Vancouver)

Canadian Mental Health Association, Bev Gutray, Jonny Morris (2015-Jun-24, Vancouver)

Cariboo Action Team, Dr. Glenn Fedor (2015-Jun-24, Vancouver)

Cariboo Child Development Centre Association, Nancy Gale (2015-Jun-24, Vancouver)

Child and Youth Crisis Program, Ocean van Samang (2015-Jun-23, Vancouver)

Rev. Dr. Steve Epperson (2015-Jun-24, Vancouver)

First Nations Health Authority, Joe Gallagher (2015-May-27, Victoria)

First Nations Health Council, Grand Chief Doug Kelly (2015-Jun-24, Vancouver)

Focus Foundation of B.C., Dr. Jeffrey J. Schiffer, Deborah (Deb) Abma (2015-Jun-24, Vancouver)

Inner City Youth Mental Health Program; St. Paul’s Hospital, Dr. Steve Mathias (2015-Jun-24, Vancouver)

Mountainside Secondary School, Jeremy Church (2015-May-6, Victoria)

Dr. Patricia Peterson, Dr. Bill Morrison (April 13, 2015, Victoria)

Provincial Health Services Authority, Connie Coniglio, Jana Davidson (2015-Jun-24, Vancouver)

The Sandbox Project, Dr. Stanley Kutcher, Dr. Zak Bhamani, Dr. Christine Hampson (2015-Jun-24, Vancouver)

Brent Seal (2015-Jun-23, Vancouver)

Shuswap Nation Tribal Council, Chief Wayne M. Christian (2015-Jun-24, Vancouver)

Simon Fraser University, Faculty of Health Sciences, Dr. Charlotte Waddell (2015-Jun-23, Vancouver)

Dr. Ingrid Söchting, Dr. Colleen Wilke (2015-Jun-23, Vancouver)

University of Victoria (WITS Program), Kathreen Riel (2015-May-6, Victoria)

Appendix B: Written and Video Submissions

Abbotsford Community Services, Simone Maassen	Mae Burrows
Brenda Anderson	Christa Campsall
Big Brothers Big Sisters, Tim Bennett	Campus View Elementary Parent Advisory Council, Yra Binstead
Board of Education, School District 62 (Sooke), Christine McGregor	Alan Cassels, Rob Wipond, Janet Currie
Bothwell Elementary School, Surrey, Tess Souder	Child & Youth Health Network of the Capital Region, Petra Chambers- Sinclair
Jan Bradley	Child Development Institute, Leena Augimeri
British Columbia Healthy Living Alliance, Rita Koutsodimos	Chloe Grace Foundation, Dana Beecroft
British Columbia Pediatric Society and B.C. Psychological Association, Kelly Price	Chloe Grace Foundation, Linda Farrow Bullock
British Columbia Schizophrenia Society, Sharon Evans	Chloe Grace Foundation, Rheanne Kroschinsky
British Columbia Schizophrenia Society, David Halikowski	Chloe Grace Foundation, Kerry Raitt
British Columbia Teachers' Federation, Jim Iker	Chloe Grace Foundation, Shannon Roylance
British Columbia School Trustees Association, Teresa Rezansoff	Chloe Grace Foundation, Leanne Ryan
Jessica Broder	Clements Centre Society, Lisa Chileen
Amy Bullock	Community Foundation of the South Okanagan Similkameen, Aaron McRann
Burnaby Healthier Community Partnership, Margaret Manifold	Community Options Society, Andee Dale
	Guy Cooper

Directorate of Agencies for School Health, Kathy Cassels	Tess Vally
First Nations Education Steering Committee, Deborah Jeffrey	Tracy Van Raes
Tricia Highley	Vancouver Foundation, Trilby Smith
Impact British Columbia, Diane Goossens	Victoria Child Abuse Prevention and Counselling Centre, Judith Wright
Susan Inman	Amy Woodruffe
Institute for Sexual Minority Studies and Services, Dr. Kristopher Wells	Youth Esteem Strategy Project (YES project), Amberlee Erdmann
Shelly Johnson	Youth Esteem Strategy Project (YES project), Katherine Harris
Parveen Khtaria	Youth Esteem Strategy Project (YES project), Honor Hollman
Kids Help Phone, Jamie Slater	Youth Esteem Strategy Project (YES project), Mia McBryde
Reinhard Krausz	Youth Esteem Strategy Project (YES project), Melissa Redfern
Michelle and Bob Laird	Youth Esteem Strategy Project (YES project), Victoria Ritchie
Linda Proctor and Jo-Anne Landolt	Youth Esteem Strategy Project (YES project), Haley Russell
Emma Lee	Youth Esteem Strategy Project (YES project), Jada Smith
Kim Lyster	Zonta Club of Victoria, Carole Didier
Matsqui Abbotsford Impact Society, Brian Gross	Zonta Club of Victoria, Barbie Zipp
Terri McKinlay	
Dr. Faye Mishna	
David Newman	
North Shore Schizophrenia Society, Nancy Ford	
Kristy Porter	
Rock Solid Foundation, Dorian Brown	
Royal Canadian Mounted Police, Rafael Alvarez	
Royal Canadian Mounted Police, Scott Hilderley	
Carly Scholze	
SpeakBOX, Aidan Scott	

