

Still Waiting

First-hand Experiences with
Youth Mental Health Services in B.C.
April 2013



REPRESENTATIVE FOR
CHILDREN AND YOUTH

April 9, 2013

The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting the report *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.* to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 6(b) of the *Representative for Children and Youth Act*.

Sincerely,

A handwritten signature in black ink, reading "mesturpellafond". The signature is written in a cursive, lowercase style.

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. Craig James, QC
Clerk of the Legislative Assembly

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Acknowledgements

This report would not have been possible without the contributions of numerous individuals who participated in its development. The Representative would like to thank the many dedicated professionals who care so passionately about the youth they serve and who generously gave of their time to share their experiences, observations and ideas. The number of responses was overwhelming and we greatly appreciate the compassion and professionalism they bring to their work.

The Representative is especially indebted to the youth and their families and caregivers whose voices have so strongly contributed to this report. Their willingness to honestly share their trials and tribulations – and their successes – is most appreciated. It is through their experiences that we can begin to understand the reality of seeking support from a mental health system that is fragmented and inconsistent, a system in which supports are often provided too late and information is not easy to come by.

Special thanks must also go out to the many organizations that put time and energy into working with the Representative to enable individuals from all areas of the province to share their perspectives in the surveys, focus groups and individual interviews:

BC Children's Hospital

BC Pediatric Society

British Columbia health authorities (Fraser Health, Interior Health, Northern Health, Vancouver Island Health, Vancouver Coastal Health, Provincial Health Services)

British Columbia Medical Association

Canadian Academy of Child and Adolescent Psychiatrists

Canadian Mental Health Association, B.C. Division

Federation of Community Social Services of BC

F.O.R.C.E. (Families Organized for Recognition and Care Equality) Society

McCreary Centre Society

Ministry of Children and Family Development

Ministry of Health

Simon Fraser University Researchers Marlene Moretti and Gillian Watson.

Executive Summary

In the course of her work, the Representative has been alerted to the serious shortcomings, poor communication and inconsistencies that plague the system serving British Columbia children and youth who have mental health problems.

Concerns and frustrations have often been voiced to the Representative by the youth and families attempting to access mental health services – as well as by many professionals trying to help these families.

This issue has been flagged in the three most recent reports of the Representative – *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm* (2012); *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children* (2013); and *Much More than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care* (2013). The findings in these reports have identified significant shortcomings on the part of the Province to address the mental health needs of young people and their families.

All of this prompted the Representative to launch a review of mental health services for youth in B.C., with a particular focus on youth between their 16th and 19th birthdays. This focus was selected because it has been identified as a particularly problematic period, when youth are transitioning to adulthood and attempting to navigate between services for children and the very different system in place for adults ages 19 and over.

The Representative believed it was critical to hear directly from youth and their families about their experiences in the mental health system. The review included surveys, focus groups and interviews with 853 youth, parents, caregivers and/or professionals who work with youth with mental health problems. Researchers from Simon Fraser University and the McCreary Centre, a non-government, not-for-profit society, worked with the Representative to collect information about the experiences of 89 young British Columbians who faced mental health problems before the age of 19.

The results of this review paint a disturbing picture, which is well-characterized by this comment from a physician participant: *"The system is broken. I've become so angry, frustrated and burnt out. The biggest frustration is the systemic disarray."*

Indeed, this review reveals a fractured youth mental health system in B.C. that is confusing and frustrating for youth and their families to navigate. Youth and their families identified long waits to see mental health professionals or to receive treatment as a major barrier – some even spoke of being on waitlists for more than a year. Said one youth who took part in the McCreary study: *"I'm tired of asking for help, because I don't get help or I don't get a response."*

There are a number of other significant barriers to youth receiving help, ranging from a general lack of understanding about mental health on the part of youth, their families and potential “first-responders” such as educators or family doctors, to gaps in communication and services for youth transitioning to the adult mental health system. This review found that a lack of intensive, intermediate supports in B.C. communities, mental health services that too often are not well-designed for youth accessibility and a lack of support for the families who are caring for a youth with mental health problems are other serious concerns.

Families and caregivers strongly indicated that they are not well-served by the system. Those surveyed consistently identified wait times as a significant barrier, with about half of parents and caregivers indicating that their child had been placed on a waitlist. Said one parent: *“We had to wait until my daughter became violent before even a semblance of help appeared.”*

This is simply not good enough. For adolescents and those entering their adult years, this is a prime window for prevention, intervention and treatment. Without a system that adequately addresses their mental health needs in a timely fashion, that window can be slammed shut, and the consequences can be life-long.

The review also points to a lack of family involvement in mental health support planning and services. About three-quarters of parents and caregivers indicated that, after taking their child to a hospital Emergency Room, they did not receive enough information about the youth’s mental health condition or about follow-up supports and services available in the community. About one-third of parents and caregivers indicated they had not had access to support services to help them cope, and several parents and caregivers identified a lack of respite services as a major issue.

Youth who received hospital inpatient or residential treatment for mental health problems and their families indicated that they were not properly supported in the youths’ return to home and community. Said one parent: *“As for family support, there was not enough. It’s been exhausting. The hospital Emergency Ward sent her home to a traumatized family. There really needs to be more continuity of support . . .”*

A similar gap exists as youth transition from child and youth mental health services to those designed for adults. Less than one-quarter of adult mental health clinicians indicated that they are usually or always involved in planning for these transitions before they actually take place. Just half of these clinicians indicated that they usually or always received information on youths’ mental health histories before beginning services with them.

Such communication lapses between service providers surfaced as a major concern. Child and youth mental health practitioners indicated that, on average, when their clients visit an ER in a crisis situation, they are only notified of those visits about half the time. Family doctors, identified as the foundation

of primary mental health care by the government, indicated that when child and youth mental health staff conduct an assessment of one of their patients, on average they are only provided with the results of that assessment about half the time.

The Ministry of Children and Family Development's (MCFD) 2003 five-year *Child and Youth Mental Health Plan* listed a continuum of services that should be available across the province. However, inconsistencies abound in the services actually delivered in different areas of B.C. today. In fact, a single set of core services does not exist across the province. What is available in each region, and in some cases each community, is different. Where services are similar, delivery mechanisms may differ. As reflected in focus group results, this can lead to frustration and difficulties for desperate families in need of help.

The Representative's analysis also indicated that there is a lack of specialized acute care in hospitals for youth with mental health problems depending on their age and where they live. For most of B.C., there is also a distinct shortage of intensive, community-based intermediate treatment and supports. In short, there isn't much available between acute care in hospitals and existing community services. It is clear that current treatment and supports are not meeting the mental health needs of many youth.

One of the goals listed in MCFD's current Service Plan is for child and youth mental health (CYMH) services to *"offer a wide range of mental health interventions to promote mental health, provide early intervention and intervene appropriately to address mental health concerns for children, youth and their families."*

While supportive of this goal, the Representative notes that government is falling far short of reaching it. The only subsequent Service Plan performance measure listed by MCFD in this area is to increase the number of mental health sessions conducted by telephone during the next three years – hardly a significant step to address the myriad deficiencies identified in this report.

In the process of conducting this review, it has become obvious to the Representative that the mental health system for children and youth in B.C. is actually not a system at all, but rather a patchwork of services that is inconsistent from region to region and community to community. It is confusing for youth, their families and even the professionals who serve them and, therefore, actually getting the required services is often near to impossible.

The initial promises of MCFD's 2003 five-year *Child and Youth Mental Health Plan* remain unfulfilled and government's 10-year mental health plan does not sufficiently address the inadequacies identified in this report. There has not been enough action on these plans. This review can only conclude that there remains a distinct lack of provincial leadership and accountability when it comes to actually providing youth mental health services in B.C., and recommends that this leadership void be addressed as the first step toward building a truly comprehensive mental health system for youth in B.C.

Introduction

The purpose of this review was to determine how responsive the B.C. mental health system is to the needs of youth ages 16 to 18 (up to their 19th birthday) and their families and to examine opportunities for both immediate and future improvements to that system.

This is not an exhaustive review of mental health services available to all children and youth in the province. The Representative chose to focus on the 16 to 18 age group for this report because this time of transition from adolescence to adulthood can often be challenging for youth who have mental health problems and for their families as well. These are formidable development years as youth make the transition from dependence to independence. Complicating matters, mental health services for children and youth cease when a youth turns 19, requiring a transition to adult mental health services.

The Transition Years

A growing body of research has examined mental health challenges and services for youth between the ages of 16 and 24. These transition years are characterized by a complex interplay of biological, cognitive and psychosocial issues, including neurological changes in the brain affecting risk-taking and decision-making; transitions in family and peer relationships, including intimate relationships; and new social roles related to education, employment and housing (Davidson, 2011). For optimal adolescent development, youth at this stage generally require support as they evolve to become self-sufficient adults and discover a sense of self and identity.

Transition in these areas is complicated for youth with mental health problems because they often experience delayed development and have younger “developmental ages” than their chronological ages (Davidson, 2011). Mental health problems can compound the typical challenges that older adolescents face during this transition phase, resulting in greater struggles and greater need for supports.

The Representative notes that this period of transition to adulthood represents an important opportunity for appropriate interventions to achieve positive outcomes:

“Early, effective intervention, targeting young people aged 12 to 25 years . . . is required if we wish to reduce the burden of disease created by these disorders. A strong focus on young peoples’ mental health has the capacity to generate greater personal, social and economic benefits than intervention at any other time in the lifespan and is therefore one of the ‘best buys’ for future reforms.” (McGorry, 2007)

The Representative has learned through this review that the developmental needs of transition-age youth are being poorly met in B.C. Service provision is often divided between pediatric and adult mental health service delivery systems, neither of which has historically created services specifically for transition-age youth. This gap in service has been exacerbated by age-eligibility requirements and lack of coordination between systems that have left many vulnerable youth unsupported so that “... *the maximum weakness and discontinuity in the system occurs just when it should be at its strongest*” (McGorry, 2007).

The personal impact of distress and dysfunction resulting from an individual's mental health problems is a cost that cannot be fully calculated. However, a conservative estimate is that mental health problems and illness cost the Canadian economy \$50 billion per year in service costs and lost productivity (Lim, 2008). B.C.'s share of this burden is more than \$6 billion annually (Ministry of Health Services and MCFD, 2010). These figures do not include costs related to the criminal justice, education or child welfare systems (Mental Health Commission of Canada, 2012).

The costs of mental health problems and mental illness among children and youth also project into the future, and are more onerous when appropriate supports are not provided before the transition to adulthood. While the costs to society are huge, the cost to individual youth and their families can be absolutely devastating.

“Unassisted mental health problems among adolescents are associated with low educational achievement, unemployment, substance use, risk-taking behaviours, crime, poor sexual and reproductive health, self-harm and inadequate self-care – all of which increase the lifetime risk of morbidity [illness] and premature mortality [death]. Mental health problems among adolescents carry high social and economic costs, as they often develop into more disabling conditions later in life. Young people whose mental health needs are recognized function better socially, perform better in school and are more likely to develop into well-adjusted and productive adults than those whose needs are unmet.” (UNICEF, 2011)

Literature suggests that fewer than half of youth with mental disorders receive mental health services (Canadian Association of Paediatric Health Centres, National Infant, Child, and Youth Mental Health Consortium Advisory, and Provincial Centre of Excellence for Child and Youth Mental Health at Children's Hospital of Eastern Ontario, 2010). Based on a review of advocacy cases, reviews of critical injuries and deaths and surveys conducted for this report, the Representative believes that youth in B.C., ages 16 to 18, with mental health problems are not receiving the services they require in a timely manner to address and manage their mental health problems.

The Representative is also concerned that these transition-age youth are not supported to ensure smooth transitions to the adult system. Most mental health services are delivered through discretionary programs by a variety of organizations. It is unclear if these services are designed to offer coordinated care to meet the mental health needs of young people.

The Representative has a mandate to monitor, review, audit and conduct research on the provision of a designated service by a public body for the purpose of making recommendations to improve the effectiveness and responsiveness of that service, and to comment publicly on any of these functions. Publicly funded mental health services for children and youth up to their 19th birthday are defined as “designated services” under the *Representative for Children and Youth Act (RCY Act)*.

Scope of this Review

This report reviews publicly funded mental health services for youth in B.C. These services are the responsibilities of MCFD, the Ministry of Health (MoH), and health authorities and are delivered by government offices, community agencies, in hospitals or through treatment facilities. More specifically, this report looks at emergency, assessment, treatment and support services available to youth ages 16 to 18 and their families, barriers to accessing these services, how well service transitions are coordinated, and how well youth are supported in their transition to adult services.

Concerns about services for the 16 to 18 age group that have been brought to the Representative’s attention include a lack of services, long wait times and youth falling through the cracks when moving between services. This is especially the case as youth turn 19 and are no longer eligible for child and youth mental health services, but still require support.

In determining the scope for this review, the Representative considered issues identified in the 2003 MCFD Child and Youth Mental Health Plan and in any evaluations conducted during the last decade. The Representative also conducted a scan of academic literature and a jurisdictional review. This confirmed that the absence of a seamless system of care when youth move between mental health services is not unique to B.C. When the Representative’s office consulted B.C. experts in child and youth mental health, these experts agreed that access to services and continuity of mental health care continue to be pressing issues for children and youth, particularly for youth ages 16 to 18.

This report explores:

- 1) How easy is it for youth and their families to find and receive services, and what barriers, if any, exist to receiving services?
- 2) How well supported are families to care for their youth with a mental health problem?
- 3) What is the spectrum of mental health services publicly available for B.C. youth – from emergency care and intensive, specialized care to community-based services – and how responsive is this care to the needs of transition-age youth?
- 4) How well do service providers communicate and coordinate services when youth move between services?
- 5) How well are youth supported in their transition to adult services?
- 6) How responsive is the overall system design in addressing the mental health needs of transition-age youth?

Some sub-populations of youth are particularly vulnerable, and may require unique care and supports. These groups include:

- youth in the care of government
- youth living with a developmental disability
- Aboriginal and First Nations youth
- immigrant and refugee youth
- gay, lesbian, bi-sexual or transgendered youth
- homeless youth
- youth with a parent suffering from a mental illness.

While a diverse group of youth contributed to focus groups for this project, the Representative recognizes that the particular needs and experiences of these specific groups of young people warrant separate attention.

B.C. has recently taken some steps in this direction. MCFD conducted an internal review of its regional Aboriginal CYMH plans in 2011, and the Tripartite Strategy Council on Mental Wellness and Substance Use is currently developing a strategy for addressing First Nations and Aboriginal mental wellness that will include youth. In addition, the Representative's report *Trauma, Turmoil and Tragedy* provides findings and a recommendation specific to the mental health needs of children and youth in care.

Methodology

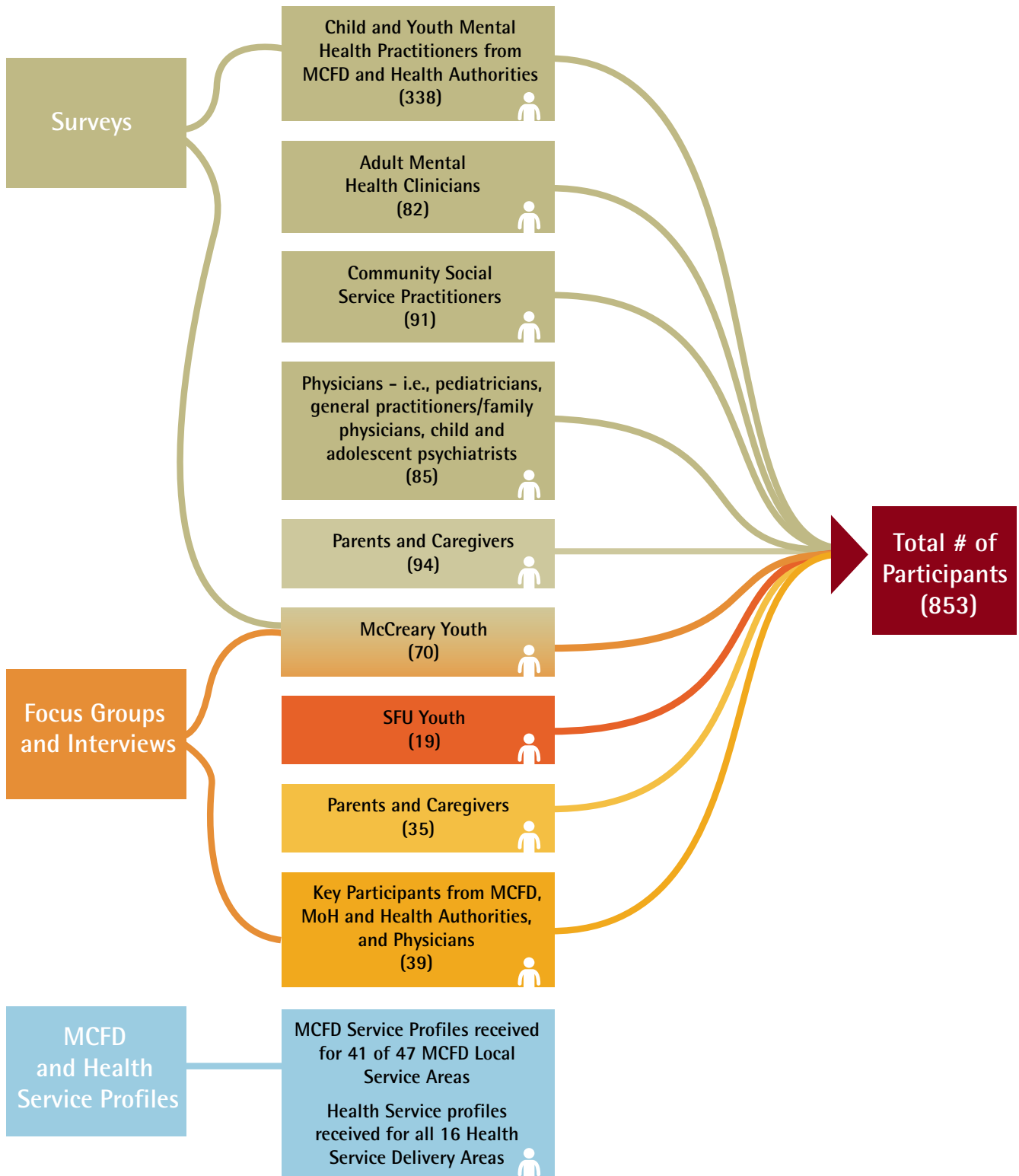
This report was prepared by building on previous work and employing various information-gathering tools to understand how the system of services functions, how it is meant to function, and what might be done to improve the system to better support youth in B.C.

Focus groups were held for youth with mental health problems, parents and caregivers, mental health practitioners and physicians. These groups, along with community social service practitioners, also completed surveys about their experience with the youth mental health system. One-on-one interviews were held with youth, physicians and policy makers and managers from MCFD, MoH and health authorities. Data from the focus groups and interviews were analyzed by identifying key themes related to the availability, accessibility, and coordination of services for youth with mental health problems.

It is important to note that the perspectives and experiences of youth, parents and caregivers, and service providers described in this report may not be representative of the experience of all individuals who access or work within the mental health service system in B.C. Nevertheless, these findings provide the most recent account of the experiences of families with the publicly funded mental health service system in B.C., and identify specific areas that must be addressed in order to better support youth with mental health problems.

This review was further informed by an analysis of MCFD policies, standards and protocols related to mental health services for children and youth; a comprehensive review of literature on child and youth mental health and

Figure 1. Youth Mental Health Project: Research Tools and Number of Participants



well-being; a cross-jurisdictional review of mental health services for youth; and a best practices literature review on service transitions for youth ages 16 to 18.

In developing the questions used in the various focus groups, interviews and surveys, the Representative looked at best practices identified from jurisdictional and literature reviews on the coordination of mental health services for youth. The Representative also referenced issues identified in the office's work in advocacy, and critical injury and death reviews and investigations.

To ensure that the interview and survey questions could capture the range of experiences of families, preliminary data collected from focus groups with parents and caregivers of youth with mental health problems across B.C. was used to refine questions. The topics addressed in the focus groups, interviews and final survey questions were further reviewed by key people in the child and youth mental health field.

In order to distribute surveys and initiate interviews and focus groups, the Representative worked in collaboration with:

- MCFD
- health authorities
- the F.O.R.C.E. Society
- the Canadian Mental Health Association, BC Division
- BC Children's Hospital
- the Canadian Academy of Child and Adolescent Psychiatrists
- the BC Pediatric Society
- the BC Medical Association
- the Federation of Community Social Services of BC
- the McCreary Centre Society
- researchers from Simon Fraser University
- members of the Representative's Advisory Committee on Services to Children and Youth with Special Needs with expertise in mental health services.

The following key areas were explored in this report:

- **Availability of services for children and youth with mental health problems**
 - CYMH regional contacts from MCFD and from five regional health authorities were given a list of publicly funded mental health and health services supporting children and youth and asked to indicate whether the services existed in specific service areas and, if so, the age group that each service served.
- **Accessibility and coordination of services for youth ages 16 to 18**
 - A combination of survey, focus group, and interview responses from child and youth mental health practitioners, adult mental health clinicians, community social service practitioners, physicians, parents, caregivers and youth was used to assess the accessibility and coordination of services. Both online and paper surveys were available for parents, caregivers and physicians to ensure that there were no technological barriers to participation.

- Individualized surveys were distributed to:
 - child and youth mental health practitioners from MCFD and the health sector
 - adult mental health clinicians working in community and outpatient settings
 - community social service practitioners working in a social service organization and working with youth (ages 16 to 18) with mental health problems in areas such as youth justice, addictions, mental health and child welfare
 - pediatricians, family doctors and child and adolescent psychiatrists
 - parents and caregivers of youth ages 16 to 24 with a mental health problem
 - youth connected to the Representative's office through the McCreary Centre Society and researchers at Simon Fraser University.
- **Overview of the mental health service system for youth**
 - Interviews and focus groups with key people working in the mental health service system added to data received on the availability, accessibility and coordination of services.
 - Interviews and focus groups were conducted with policy makers and managers from MCFD, MoH and health authorities and physicians to gain an overall understanding of the mental health service system for youth, specifically looking at:
 - roles and responsibilities of service providers
 - communication and coordination between service providers across transitions (i.e. between youth services and between youth and adult services)
 - what is working well and what is not in the youth mental health service system
 - suggestions for change.

For further information on participants, data considerations and survey data findings, see Appendices A, B and C.

Background

What is Mental Health?

MoH and MCFD use the World Health Organization (WHO) definition of mental health:

“Mental health is essential to physical health, personal well-being, and positive family and interpersonal relationships. The World Health Organization describes mental health as a state of well-being in which the individual realizes his or her own abilities, copes with the normal stresses of life, works productively and contributes to his or her communities. Good mental health is much more than the absence of mental illness – it enables people to experience life as meaningful and to be creative, productive members of society.” (Ministry of Health Services & MCFD, 2010)

Positive mental health is not merely the absence of a mental illness, but also the ability to manage the stresses and difficulties that life can bring. Positive mental health is necessary for young people to reach their potential and to participate in and enjoy life to its fullest.

However, positive mental health is not a given. A conservative estimate of the chances of a Canadian having a mental illness in his or her lifetime is one in five (Kirby & Keon, 2004a). Anybody can face experiences that challenge their mental health. Mental health problems cause distress and disrupt one’s ability to function in important aspects of life. For the purpose of this report, mental health problems range in severity from mild to severe and include diagnosed mental illnesses.

Early identification and treatment of mental health problems in children and adolescents often prevents more serious mental illness in adults. More than 70 per cent of adults living with a mental illness say they developed symptoms before age 18 but the fear of stigma often delayed them from seeking treatment (Mental Health Commission of Canada). The Representative strongly believes that government must ensure that young people in B.C. have access to appropriate care when they are faced with a mental health concern.

Numerous issues regarding child and youth mental health have been raised in the Representative’s joint monitoring reports with the Provincial Health Officer including *Kids, Crime and Care, Health and Well-Being of Children in Care: Youth Justice Experiences and Outcomes* (2009) and *Health and Well-Being of Children in Care in British Columbia: Educational Experience and Outcomes* (2007). These reports identified major behavioural and mental health problems in the school and justice systems.

The Representative’s advocacy work also speaks to a period of concern for adolescents and families when mental health problems do not appear to be adequately addressed by the health system, MCFD or other public systems of support. Issues of lengthy wait times, lack of available services and poor planning as youth move between services, have been common themes.

In addition, members of the public from across the province, including parents, pediatricians and psychiatrists, have consistently approached the Representative's office upset about the experiences faced by adolescents, in particular those between the ages of 16 and 18 inclusive, when trying to access mental health services.

Who is Responsible for Mental Health Services in B.C.?

MCFD and MoH have operational responsibility for the main streams of publicly funded mental health services for youth ages 16 to 18 inclusive. MCFD has primary responsibility for community mental health services. MoH is responsible for primary care delivered mainly by family doctors, specialized inpatient mental health care, and acute care in hospitals run by regional health authorities as well as the Provincial Health Services Authority (PHSA).¹

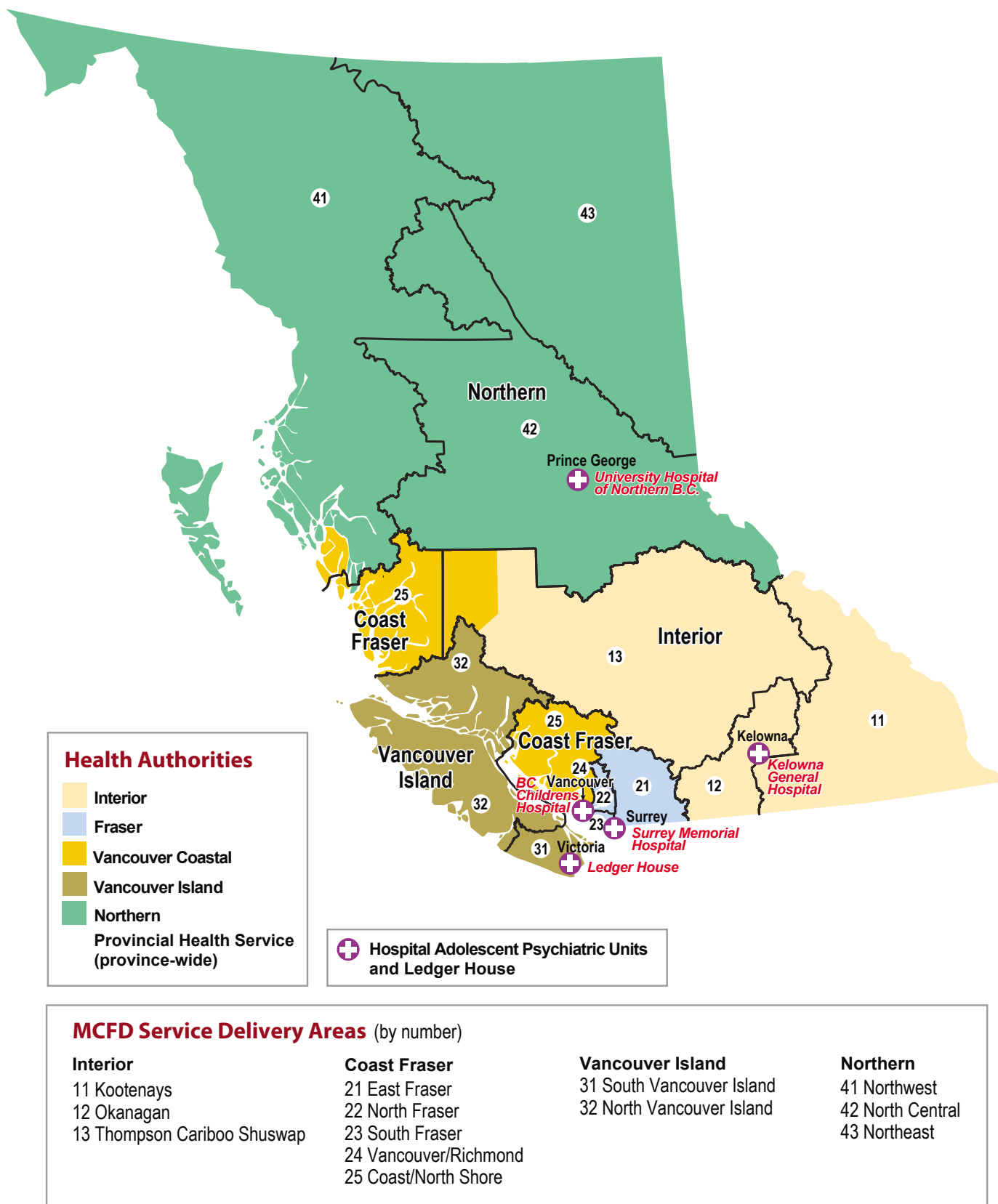
Geographically, these services are delivered by five regional health authorities, the PHSA and MCFD's 13 service delivery areas. Each health authority is responsible for the development and delivery of its own community- and hospital-based mental health services and programs. This responsibility includes establishing policies, standards and protocols consistent with legislation, provincial policies and standards. In addition, each hospital within a region is responsible for its own operating policies.

Until late 2012, MCFD operated under a four-region structure with boundaries that were largely contiguous with the five health authority regions. MCFD's current structure is four regions made up of 13 service delivery areas, which are further divided into 47 local service areas. These fit approximately within the five regional health authority boundaries (see Figure 2).

Although policies and standards for the delivery of community mental health services are the responsibility of MCFD's provincial office, each of MCFD's regions determines how these policies and standards are implemented within the region and without accountability mechanisms back to the provincial office. Consequently, MCFD delivers components of child and youth mental health services in a variety of ways across the province, and manages and operates them under a variety of structures.

¹ The *Mental Health Act* provides for the treatment of people with severe mental disorders, including involuntary admission to hospital and treatment. The Act covers both adolescents and adults, and provides for the designation of mental health facilities, psychiatric units and observation units, and the appointment of a person responsible for each designated facility. The *Mental Health Act* divides services into an adult stream (16 years and older) and a children and youth stream (16 years and under). However, the designation of facilities under s. 3 of the Act does not specifically identify facilities and units for children and youth or adolescents and the ministerial order is a list of all units and facilities (Ministerial Order M 116/2005. Updated Feb. 7, 2013).

Figure 2. B.C. Health Authorities and MCFD Service Delivery Areas as of April 2013



Primary Health Care and Youth Mental Health

The MoH describes primary health care as “a system that provides first-contact access for each new need, long-term person-focused care, comprehensive care for most health needs, and coordinated care when it must be sought elsewhere” (MoH, 2007).

In B.C., family doctors are the cornerstone of primary health care. They are also identified by MoH as the foundation of primary mental health care for all British Columbians.

This means that individuals with a family doctor should be able to go to that doctor if they believe they have a mental health problem. They should expect the doctor to assess the situation, manage the problem and, if necessary, refer them to specialized care. If the family doctor seeks other specialist services for the individual, care should be planned, coordinated and supported by the family doctor.

In some parts of the province, doctors and nurses at youth clinics and street nurses also deliver primary mental health care to youth.

How are Community Mental Health Services Delivered in B.C.?

In B.C., MCFD, health authorities, contracted service providers, pediatricians and psychiatrists in private practice deliver publicly funded community mental health services to youth. Service delivery structures and the services available vary considerably across the province.

Private fee-based mental health assessment and counselling are available throughout B.C. for children and youth. The services addressed in this report are those which are publicly available and do not require a youth, or other family member, to pay a private or additional fee. However, the Representative acknowledges that the service providers identified as linked to the public system may also provide private, fee-for-service counselling or treatment.

Psychiatrists are physicians specializing in the diagnosis and treatment of mental illness. In B.C., child and adolescent psychiatrists provide services to youth in community settings through private practice, as well as, through contracts with MCFD and health authorities.

Pediatricians specialize in the medical care of infants, children and adolescents. The level of mental health care that pediatricians provide is dependent upon each physician’s individual practice, comfort level, and the type of training they received.

Through its Child and Youth Mental Health (CYMH) services,² MCFD provides or funds community-based mental health services across the province for children

² In this report the capitalized Child and Youth Mental Health services and the acronym CYMH refer to a specific set of services delivered or funded by MCFD. The terms “child and youth mental health services” and “youth mental health services” refer to all publicly funded mental health services for these age groups.

and youth with mental health problems from birth to 18 years of age and their families, including a core set of mental health services and specialized services such as the Sexual Abuse Intervention Program, which is delivered through contracted community services.

MCFD's core CYMH services include triage, resource and support services upon referral, mental health assessment, treatment planning, and therapeutic interventions and mental health consultation. The primary focus of these services is at the local service delivery area.

MCFD also delivers Youth Forensic Psychiatric Services (YFPS), a provincial program that provides court-ordered and court-related assessment and treatment services for youth 12 to 17 years of age involved with the youth criminal justice system.³ The Maples Adolescent Treatment Centre in Burnaby, which is primarily a residential treatment facility serving all of B.C., also provides non-residential services, including home-based treatment, to youth and their families in surrounding communities. Both YFPS and the Maples are administered separately from MCFD's CYMH stream of services.

MCFD's CYMH services can be provided by teams of mental health practitioners employed by MCFD, by practitioners working for contracted agencies and by individual professionals contracted by MCFD. The mix of services delivered directly by MCFD and by contracted providers varies across the province.

In Prince George, all CYMH services funded by MCFD are delivered through a contracted agency. In Vancouver and Richmond, MCFD contracts with the Vancouver Coastal Health Authority to deliver CYMH services. In most of the province, general CYMH services are delivered directly by MCFD.

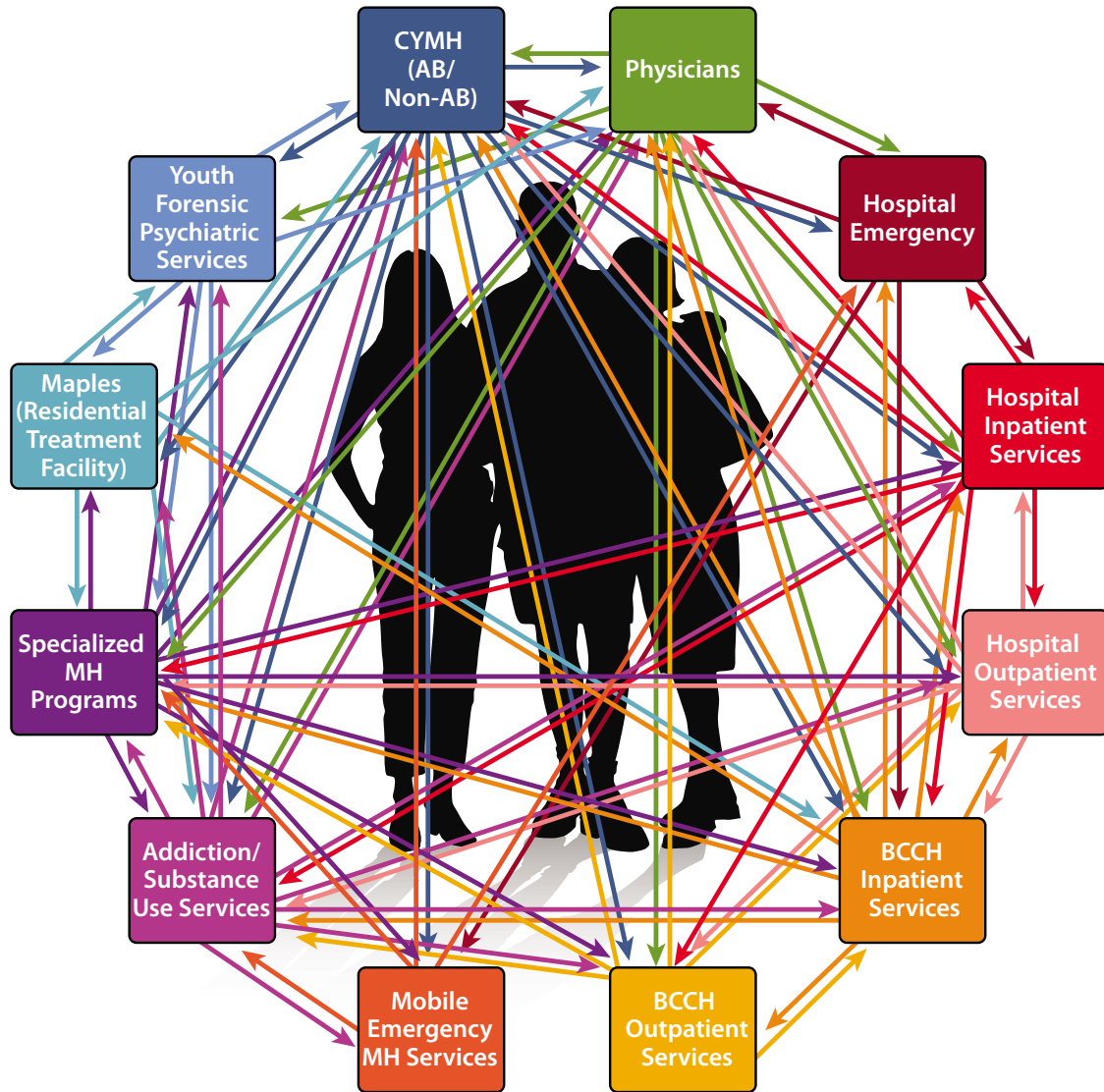
MCFD also delivers or funds distinct Aboriginal CYMH services in most areas of the province. Aboriginal CYMH includes core CYMH service functions as well as approaches designed to respond specifically to Aboriginal communities. Common themes in descriptions of local Aboriginal CYMH services received from MCFD include:

- Relationship-building with Aboriginal and First Nations communities
- Outreach by Aboriginal mental health support workers who play a liaison role with youth, families and communities
- Mental health therapy provided in a variety of settings including homes, schools and on the land
- Family-centred and community-centred services
- Holistic view of mental wellness
- Understanding of historical and multigenerational issues affecting the mental health of Aboriginal children and youth.

³ B.C.'s *Youth Justice Act* provides for the administration of youth justice in B.C. and establishes practices for the provincial administration of the federal *Youth Criminal Justice Act*, including the preparation of psychological and other reports before trial or sentencing to examine the mental and physical health of a youth, as well as prescribe practices to evaluate the health status of a young person upon admission to a youth custody centre.

Figure 3. Mental Health Formal Linkage Points

This diagram illustrates the formal linkage points between the various mental health services available to youth. Formal linkages between services can occur a number of ways, such as prescribed referral processes, court ordered services, etc.



Legend: Mental Health Services (organized by who delivers the mental health service)

MCFD	Health Authority	MCFD and Health Authority	Physicians in Private Practice
1. Child and Youth Mental Health (CYMH) Services • Non-Aboriginal CYMH stream • Aboriginal CYMH stream 2. Youth Forensic Psychiatric Services (YFPS) 3. Maples Adolescent Treatment Centre (Residential Treatment Facility)	4. Hospital Emergency 5. Hospital Inpatient Services (e.g., adolescent psychiatric unit, general ward, Ledger House) 6. Hospital Outpatient Services 7. BC Children's Hospital (BCCH) Inpatient Services (e.g., adolescent psychiatric unit, general ward) 8. BC Children's Hospital (BCCH) Outpatient Services 9. Mobile Emergency Mental Health (MH) Services	10. Specialized Mental Health (MH) Programs • EPI Program • Eating Disorder Program 11. Addiction/Substance Use Services	12. Physicians

Other mental health services available to First Nations and Aboriginal youth in B.C. can vary depending on factors such as whether their nations have signed treaties, whether youth live on or off reserve and how services are funded. For example, the federal government funds short-term crisis counselling for status Indians. Federally funded and First Nations-delivered services are not within the scope of this review. The Representative believes that coordination and clear roles and responsibilities for service providers are important as the many jurisdictions involved in delivering and funding services create increased challenges in accessing mental health services for many First Nations and Aboriginal youth.

Regional health authorities also provide some community-based and outpatient services to youth ages 16 to 18 who have mental health problems. Some acute hospital-based levels of care, such as acute home-based treatment, are now delivered through outreach to youth in home and community settings.

In some communities, community-based youth mental health services delivered or funded by regional health authorities include mobile emergency response, day treatment programs and psychosocial supports. Again, the variety and availability of outpatient and community-based programs delivered by health authorities differs from region to region and from community to community.

In addition, regional health authorities deliver youth addiction services other than those for youth in the justice system which are provided or funded by MCFD. The Representative has not reviewed youth addictions services, but has explored issues related to services for youth with concurrent mental health problems and substance use problems. Because of the high rate of mental health problems among youth with substance use problems, youth addictions services are particularly relevant to youth mental health. Some regional health authorities offer services specifically for youth with concurrent mental health and substance use problems.

Adult Mental Health (AMH) services delivered by regional health authorities are also part of the service system that touches youth ages 16 to 18. With a main service population of people with severe mental illness, most adult mental health programs begin at age 19 and offer case management and therapeutic programs. For youth who are likely eligible for AMH upon turning 19, planning for their transition from CYMH services is supposed to start by their 17th birthday or as soon as it becomes apparent that the youth will need ongoing support.

Specialized Community Mental Health Programs for Youth

Health authorities and MCFD share responsibility for specialized programs for youth with specific mental illnesses. For example, the Early Psychosis Intervention (EPI) program is delivered in a variety of forms across the province. EPI services are available to some youth, with eligibility starting between ages 13 and 17 depending on location, and serve young adults up to age 30. The EPI program was developed in partnership by MCFD and MoH and is delivered collaboratively in some areas.

Regional health authorities also have specialized eating disorder programs for youth and adults in all regions except Vancouver Island, where these services are provided by MCFD. MCFD also offers an Eating Disorders program in the North Fraser area. As with EPI, eating disorder services delivered through health authorities and MCFD regions tend to have more specialized programs in larger urban areas and rely on generalist mental health clinicians elsewhere.

Hospital Emergency Services

General hospitals provide acute emergency care through Emergency Rooms (ER). ERs are available for anyone experiencing a mental health crisis and can provide initial assessment and immediate stabilization. Many ERs may also provide referral to community-based services.

Hospital Inpatient Services

When admission to hospital inpatient services is necessary, youth are admitted to general, pediatric, adult psychiatric or adolescent psychiatric wards depending on their age and which wards are available at a given hospital.

Inpatient services provide assessment and treatment, including medications and stabilization for youth with acute mental health problems. The extent to which assessment and treatment services address the specific mental health concerns of a youth is dependent upon the individual staffing complement and resources available at each hospital.

Hospitals with psychiatric wards and specialized residential mental health resources are designated as mental health facilities under B.C.'s *Mental Health Act*. This Act provides for voluntary and involuntary admission to a designated mental health facility. The Representative is reviewing services only in terms of the communication and coordination that occurs and not on the voluntary or involuntary nature of services.

Adolescent Psychiatric Units (APUs) are specialized regional resources located in regional hospitals that serve youth from other communities. Vancouver Island Health Authority's (VIHA) Ledger House is a stand-alone regional facility that provides acute, in-patient, hospital-based psychiatric services for children and youth ages six to 16. There are five adolescent psychiatric units located across the province, including Ledger House (see Table 2, p. 60).

Specialized Provincial Mental Health Facilities

The most specialized level of mental health care in B.C. is delivered through two provincial mental health treatment facilities in the Lower Mainland and one on Galiano Island. The two Lower Mainland facilities are BC Children's Hospital in Vancouver, operated by the PHSA, and the Maples in Burnaby, operated by MCFD. These two facilities are able to admit children and youth for longer periods than general hospitals. These are services designed for those children and youth who require the most intensive care. Both facilities provide specialized services for youth with specific mental illnesses and complex needs as well as outpatient services to youth in surrounding areas.

The Maples does not take emergency admissions. Youth typically are admitted on a planned basis, referred by community-based CYMH teams for inpatient services as well as short-term respite services on occasion. As well, the Maples provides forensic treatment services and is designated under the *Mental Health Act* as a provincial tertiary mental health facility.

BC Children's Hospital handles emergency response, stabilization and short-term treatment, and specialized diagnosis-specific treatment programs. Longer-term treatment is sometimes provided. BC Children's Hospital also has an eating disorders unit which can treat 14 youth up to the age of 19.

Woodstone Residence on Galiano Island is a residential treatment facility specifically for young people ages 17 to 24 with eating disorders. Woodstone Residence is funded by MoH and VIHA.

Youth Using MCFD CYMH Services in B.C.

In Canada at any given time, approximately one in seven children and youth between the ages of four and 17 years experience mental disorders that impair their functioning at home, at school, and in the community (Waddell, McEwan, Shepherd, Offord, & Hua, 2005; Waddell, 2007). Mood, anxiety, and behavioural disorders are the mental disorders most commonly experienced by children and youth (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Waddell et al., 2005).

Issues about access to services for mental health problems have become a growing concern for the Representative. In fiscal 2011/12, at least four per cent of the Office's advocacy cases involved a child or youth with a mental health concern. This percentage increased to six per cent of cases, between April 2012 and January 2013. Accordingly, one aim of the current review was to understand the overall number of youth and their profiles (e.g. age, gender, and DSM-IV classification⁴) who are currently accessing services from B.C.'s publicly funded mental health service system.

⁴ The Diagnostic and Statistical Manual of Mental Disorders – 4th Edition (DSM-IV) provides standard diagnostic criteria for classifying mental disorders among children and adults. The DSM-IV uses a multiaxial system to facilitate a comprehensive assessment. Axis I includes Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention, Axis II includes Personality Disorders and Mental Retardation, Axis III includes General Medical Conditions, Axis IV includes Psychosocial and Environmental Problems, and Axis V includes a Global Assessment of Functioning.

There is no central database of information for all youth who access publicly funded mental health services in B.C. There is also no single method of collecting and managing data on the number of youth who use each mental health service. For example, the BC Medical Services Plan collects data on patient visits to physicians in private practice, and individual hospitals collect data related to patient stays on hospital wards across the province. Both MCFD and the health authorities also collect and manage their own data on the child and youth mental health services that they each deliver.

The Representative asked MCFD to include data on transition-age youth 16 years or older who were either waiting for or currently receiving MCFD CYMH services as of Jan. 22, 2013. Information provided included the age, gender, and the primary mental health classification based on the Axis I and Axis II DSM-IV classifications.

Data provided by MCFD included youth who were eligible for MCFD CYMH services, clients of all ages in the Vancouver Island Eating Disorders Program and clients who are receiving Family Support services from MCFD.⁵ The data provided does not include youth who were being served by most of MCFD's contracted organizations and by CYMH offices within the Vancouver Coastal Health Authority. In addition, the number of youth who were not eligible for MCFD CYMH Services (and consequently may have been re-directed to other supports), and the number of youth who were receiving other supports in the private and public health sectors were not included.

Overall, there is insufficient data to accurately determine the exact number of youth who are waiting for or receiving MCFD CYMH services and supports or to draw any conclusions about the mental health concerns for which youth are seeking assistance.

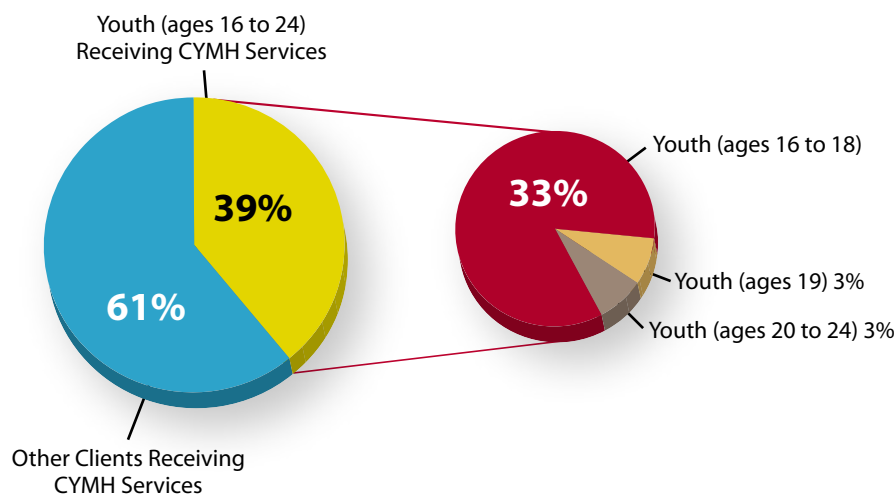
Despite these limitations, analysis of available data provides a basic understanding of the number of transition-age youth with mental health problems who are receiving MCFD CYMH services in B.C.

⁵ Family Support is a new case type that is still being implemented. This case type is chosen only when a child or youth older than 12 years of age is not engaging in treatment and the parents are requesting support. Accordingly, the case is opened in one of the parents' names. MCFD does not know how widely this case type is being used and is not able to identify which cases with an adult as the client are under this new case type.

Transition-Age Youth Using MCFD CYMH Services

Based on the data received from MCFD, on Jan. 22, 2013, at least 4,883 clients (including infants, children and youth) were receiving MCFD CYMH services.⁶ About 39 per cent of these clients were transition-age youth (1,899) between the ages of 16 and 24 (see Figure 4). There were more females than males receiving MCFD CYMH services (67 per cent females and 33 per cent males).

Figure 4. Percentage of Clients Receiving MCFD CYMH Services on Jan. 22, 2013



When a youth has a mental health assessment from MCFD CYMH services, a CYMH clinician will assess the youth using criteria set out in the DSM IV for specific mental health disorders classified under Axis I and Axis II. Axis I disorders typically are the most widely recognized mental health disorders, such as schizophrenia and depression, and Axis II disorders are personality disorders and intellectual disabilities.

Youth may have a primary classification on both Axis I and Axis II, or youth may have a primary classification on one Axis and not the other. In some cases, youth may not have a primary classification on either Axis I or Axis 2.

MCFD provided the Representative with data on transition-age youth and the primary mental health classification on Axis I and Axis II where available. MCFD was only able to provide a primary mental health classification for 40 per cent of transition-age youth who were identified as receiving CYMH services (752). A mental health classification was not available for the remaining 60 per cent of youth (1,147).

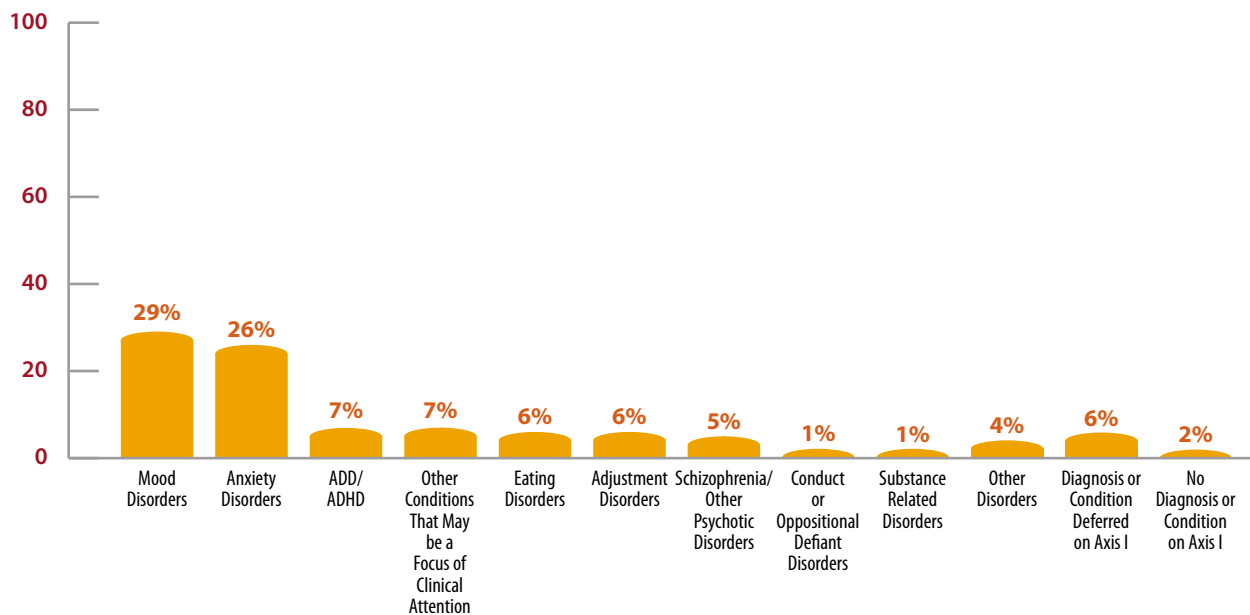
⁶ The numbers reported do not include youth who were being served by most of MCFD's contracted organizations and by CYMH offices within the Vancouver Coastal Health Authority.

The availability of mental health classifications is dependent on several factors. For instance, the youth may still be waiting for an initial assessment from a clinician or the initial assessment may be in progress. Another factor could be when the initial classification is entered into MCFD's case management system. An initial mental health classification may be recorded using a paper form immediately upon assessment. Some clinicians may record the initial classification using this paper form and choose to enter this classification into the case management system at the time of a youth's discharge from service.

Therefore, some youth may not have a mental health classification recorded in MCFD's case management system, but have a classification recorded in the clinician's paper file. MCFD only provided the Representative with mental health classifications from its case management system.

Analysis of available data showed that the two most common classifications for transition-age youth were Mood and Anxiety Disorders (see Figure 2), accounting for more than half of all cases, and the remaining youth were distributed among a number of low incidence disorders.

Figure 5. Mental Health Classifications on Axis I of Youth (ages 16 to 24) on Jan. 22, 2013



Only two per cent of youth were classified with Personality Disorders, and one per cent of youth were classified with mild or moderate Mental Retardation. More than half of the youth (57 per cent) were classified as not having either of these disorders (i.e. not having an Axis II diagnosis or condition).

In some cases, a youth may receive a classification indicating that a diagnosis or condition was deferred on Axis I or Axis II as the clinician may not have had adequate information to make any diagnostic judgment about a mental disorder. Analysis showed that an Axis I classification was deferred for six per cent of youth, and an Axis II classification was deferred for 40 per cent of youth.

Waiting Lists

The Representative asked MCFD to identify the number of transition-age youth who were waiting to see an MCFD CYMH clinician. It is telling that the waitlist information that MCFD provided did not offer a full picture of either the numbers of youth waiting for services or the nature of their mental health problems. Traditionally, MCFD has used specific data to determine the clients waiting to see a CYMH clinician. The Representative was informed that how this data is used and interpreted has been changed over the last few years. Given this change, and that MCFD's case management system's waitlist functionality is not being fully utilized, the provincial MCFD office was unable to confirm the number of youth who were waiting to see a clinician. It is important to note that MCFD policy requires that each region also have a waitlist strategy. The Provincial office could not indicate whether regions are maintaining their own waitlist information outside of MCFD's case management system.

Government Plans

Over the past decade, two government plans have set the strategic direction for youth mental health services in B.C. In 2003, MCFD produced a five-year *Child and Youth Mental Health Plan* for B.C. This was the first such plan in Canada and included strategies focused on providing treatment and support, reducing risk, building community capacity and improving performance. Subsequently, in 2006, MCFD developed Child and Youth Mental Health policies and standards that built upon the 2003 plan.

In 2010, the Ministry of Health Services (predecessor to MoH) and MCFD published *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia*. This 10-year plan takes a lifespan approach and includes strategies for supporting the mental health of children, youth, adults and seniors. Along with these plans and the related policies of individual agencies such as MCFD, health authorities and contracted community service providers, a number of protocols also exist to guide cross-agency collaboration among the diverse service providers involved in youth mental health services.

2003 Child and Youth Mental Health Plan

MCFD's 2003 *Child and Youth Mental Health Plan* provided clear direction and new resources for child and youth mental health services. It detailed a core continuum of mental health assessment and treatment services that should be available across B.C.:

- clinical and mental health consultation to families, communities and other service providers
- community-based assessment, counselling and therapy
- home-based and outreach services
- family development services such as respite and parenting groups
- day treatment
- crisis Intervention and stabilization
- residential services such as therapeutic family care, crisis stabilization and supported independent living
- acute care from hospitals.

The 2003 plan also called for effective collaboration of services across all related sectors, including primary care, schools, addictions, youth forensic psychiatric services, adult mental health, hospitals, and crisis and residential services. In particular, it identified the need for improved transitions from hospital to care in the community and from MCFD CYMH services to adult mental health services delivered by health authorities.

The plan also provided for increased collaboration and resources leading to the creation of Aboriginal Child and Youth Mental Health services delivered or funded by MCFD. At the system level, the plan created a Children's Mental Health Network to facilitate more effective planning and service coordination across sectors. In order to build capacity to monitor outcomes and evaluate activities, the plan included the creation of a comprehensive provincial children's mental health information system that was intended to be linked with larger databases in health and education.

CYMH policies and standards created in 2006 build on the 2003 plan and clarify practice expectations. It is worth noting that, with the exception of calling for improved transitions from MCFD CYMH services to adult mental health services delivered by health authorities, the 2003 plan and 2006 MCFD policies do not provide specific direction for mental health services for transition-age youth.

In 2007, B.C.'s Auditor General released a report on the implementation of the 2003 MCFD CYMH plan (Office of the Auditor General, 2007). The report found that the plan was "adequate for improving the mental health outcomes of children and youth" and that MCFD was "satisfactorily managing the plan's implementation." Looking to the future, the report also recommended the creation of a strategy for inter-sectoral collaboration in child and youth mental health services, and raised concern about how changes in MCFD's structures could affect the ministry's ability to follow through on the plan overall.

In 2008, MCFD reviewed the progress made toward the implementation of its 2003 plan. This report, *Promises Kept, Miles to Go: A Review of Child and Youth Mental Health Services in BC* (Berland, 2008), confirmed that significant progress had been achieved in the area of addressing prevention through B.C. schools. While there was room for improvement, MCFD had succeeded in establishing Aboriginal CYMH services in most of the province.

However, the review found that waitlists for service, a lack of community-based residential treatment services, inadequate communication among service providers and poor transitions between services remained problematic and needed to be addressed. The originally identified inadequacies in 2003 regarding service accessibility and continuity of care remained a problem in 2008.

Today, these same concerns continue to be raised to the Representative's office by parents, caregivers, physicians and child and youth mental health practitioners.

Healthy Minds, Healthy People: A 10-Year Plan to Address Mental Health and Substance Abuse in B.C.

Released by the Ministry of Health Services (now known as MoH) and MCFD in 2010, this report provides direction for the development of mental health and substance use services in the province. In contrast to the 2003 *Child and Youth Mental Health Plan*, which was an operational road map for developing services, *Healthy Minds, Healthy People* is an over-arching strategic-level document without operational details of how the plan might be implemented.

This aspirational plan is the first in B.C. to address mental health across the lifespan, including children, youth, adults and seniors. It is a cross-government plan led by MoH with MCFD taking the lead on the portions of the plan that address children and youth. The plan is aligned with the on-going tripartite process involving First Nations, Aboriginal and Métis communities and the provincial and federal governments to create a complementary and culturally distinct plan for supporting Aboriginal mental wellness.

Healthy Minds, Healthy People, which stresses the importance of collaboration, contains milestones for measuring progress, as well as 60 actions intended to achieve these goals:

- Improve the mental health and well-being of the population
- Improve the quality and accessibility of services for people with mental health and substance use problems
- Reduce the economic costs to the public and private sectors resulting from mental health and substance use problems.

Some actions in the plan, particularly health promotion and prevention, focus on children and their parents, while others respond more generally to the needs of children, youth and adults or do not specify the ages of those who will benefit. Annual reports published in 2011 and 2012 by MoH list a variety

of local, regional and provincial initiatives that correspond with the plan's higher level actions. Some of these initiatives focus on youth, and others address wider populations that include youth (see Table 1).

Table 1. Example Actions from Healthy Minds, Healthy People and Related Initiatives

Example Actions from <i>Healthy Minds, Healthy People</i>	Related Initiatives
Continue implementation of B.C.'s Integrated Provincial Strategy to Promote Health Literacy in Mental Health and Addictions	Launched in 2012, Mindcheck.ca is a website designed for youth and their families that offers information on mental health problems and links to resources
Increase the use of telemental health services for mental health and substance use problems	A partnership between B.C.'s health authorities and MCFD is connecting children and youth in northern B.C. to psychiatry consultations in Vancouver through the use of telehealth video conferencing
Implement gatekeeper training programs as described within the Provincial Framework and Planning Template for Suicide Prevention, Intervention and Postvention, to effectively identify and intervene with individuals at risk of suicide across the lifespan	MCFD is providing advanced clinical education in responding to suicide risk to child and youth mental health practitioners
Develop, implement and evaluate shared care models for services to children, youth and adults experiencing mental health and/or substance abuse problems	The Collaborative Psychiatry Outreach pilot project, a partnership between VIHA and MCFD, provides psychiatric consultation for children and youth in the context of an ongoing relationship between family doctors, psychiatrists and community mental health and addiction resources
Continue to develop physician guidelines for assessment and treatment of people with mental health and/or substance use problems	The BC Medical Association's Practice Support Program includes a Child and Youth Mental Health module that addresses how family doctors identify, assess, manage and treat children and adolescents with mental health disorders, including collaboration and knowledge-sharing with patients, families, pediatricians, mental health services, psychiatrists and non-government agencies

While many *Healthy Minds, Healthy People* and related initiatives are relevant to the mental health service needs of youth, the actions do not include comprehensive responses to inadequacies identified in the 2008 review of the implementation of MCFD's 2003 *Child and Youth Mental Health Plan*. These inadequacies include wait times for services and the serious lack of intermediate community residential treatment services for children.

MCFD has indicated that the 2003 CYMH plan was a good starting point and that the ministry intends to continue building on it. MCFD's 2013/2014 update to its Operational and Strategic Directional Plan identifies the following major deliverables for CYMH services and indicates that a detailed project implementation plan to achieve them will be developed by the fall of 2013.

- Improving access and waitlist management for services
- Improving active navigation and support to families waiting for service
- Improving transitions through effective protocols between community mental health services and hospitals
- Improving transitions through effective protocols between youth and adult services
- Clarifying and repositioning the role of the Maples and YFPS linked to community mental health services and the redesign of group care services
- Establishing a menu of service approaches and treatment modalities that should be available to address major presenting illnesses and conditions; mapping availability to the menu across teams; undertaking team specific recruitment, training and development plans; focusing on job and team functioning design and practice
- Developing a two-year action plan based on priorities and next steps from a fulsome community engagement and consultation process.

MCFD has indicated that it will develop the two-year CYMH action plan in collaboration with other partners and that its strategies will start with addressing the treatment of presenting mental health problems and will later incorporate prevention of mental health problems (MCFD, 2013).

While the 10-year mental health plan and MCFD's plans do respond to some of the concerns raised in this report, collectively they do not provide a comprehensive and coordinated strategy for improving mental health services for youth. As a result, the plans are missing critical components without which the fundamental problems identified will not be addressed.

Protocols

At an operational level, a number of protocols have been developed to guide cross-agency collaboration among providers of youth mental health services. In 2002, protocols were signed by MCFD and regional health authorities to guide transitions of youth with severe mental illness from MCFD's CYMH services to adult mental health services provided by health authorities. These protocols, which remain in effect, prescribe comprehensive planning that should begin on or about a youth's 17th birthday. They address housing, education, vocational, social and financial support, and treatment issues.

The Representative requested copies of other formal agreements on cross-agency service coordination from MCFD's 47 local service areas. In response to this survey, MCFD provided the Representative with 12 protocol agreements addressing coordination between hospital services, including Emergency Room and in-patient services, and CYMH services provided or funded by MCFD. Some of these protocols apply across health authorities while others guide coordination between specific CYMH offices and hospitals.

Some hospital protocols address Emergency Room procedures when a child or youth presents with a mental health problem. Others address communication and coordination between hospitals and CYMH when youth are admitted, assessed and treated in hospital, as well as procedures for discharging youth and referring them to CYMH services.

Other protocols provided by MCFD guide collaboration among services involving CYMH, schools and a variety of other community services including police. Protocols cover service coordination in a variety of realms, including assessing and responding to youth at risk of suicide, assessing and acting on threats at schools, responding to deaths or injuries that affect large numbers of children or youth, transitions from alternative to mainstream schools for youth with mental illness, referrals to CYMH and provision of CYMH services in schools. A few protocols and agreements provided by MCFD addressed services for children and youth more generally, such as collaborative planning of local children's services and the operation of a youth centre by multiple youth-serving agencies.

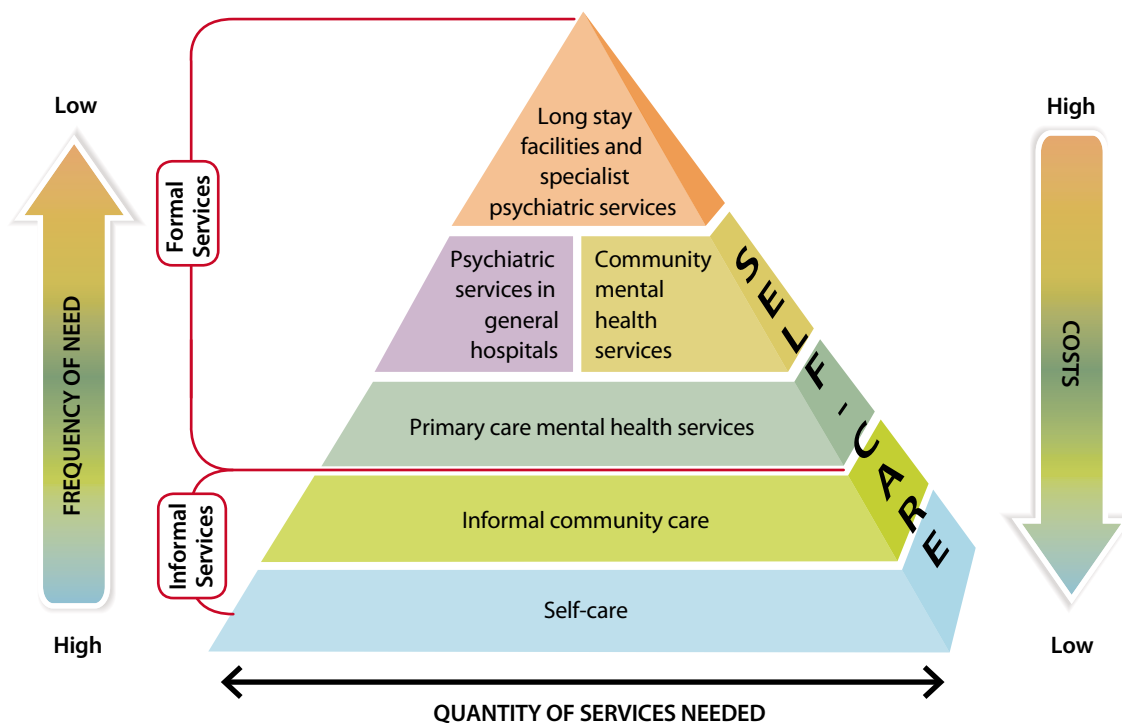
The Representative is concerned that only 12 such protocols were produced. Whether this means that other areas have not developed local protocols or were unable to provide them in a timely manner as requested is a matter MCFD management will have to review.

Experiences in the System

The WHO has published a graphic description of the optimal mix of mental health services for responding to the needs of people with mental health problems (WHO, 2009) (see Figure 6).

WHO's pyramid diagram identifies two main types of services for people with mental health problems – formal services and informal services. Formal services are those designed specifically to respond to mental health problems. Informal services include all the other supports available to people with mental health problems.

Figure 6. Mental Health Service System (WHO, 2009)



Youth, parents and caregivers have myriad experiences at each level of care identified by the WHO diagram. This section of the review describes a range of those experiences based on conversations with review participants, including youth, caregivers and physicians, as well as the Representative's overall research and analysis of the system.

Youth Voices

“How does a 13- or 14-year-old kid know how to ask for help? It is a weird thing, first of all you don’t know something is wrong cause you are so young and then you feel wrong in asking.”

“I couldn’t see what was wrong with me. I just thought, ‘everybody feels like this.’ . . . I guess I just surrounded myself with people that were like that, too, so I would not feel so messed up.”

Youth Voices

“Cause, like at 15, 16, you’re not looking for mental health resources or, you know, you’re just kind of sad and upset and don’t know why. I can’t stop drinking and I smoke weed all day.”

“Seeking out help wasn’t a step I was ready to make.”

Informal Services

Self-Care

Self-care is the most informal type of support for youth with mental health problems. It includes youth caring for themselves and receiving the care of family and friends.

Mental health self-care takes many forms, such as managing stress, cultivating healthy relationships and keeping physically active. Seeking help when needed, engaging in planning for mental health services, and participating in supports and treatment are also forms of self-care.

A key to self-care is for the youth and their family to recognize they have a mental health problem and be willing to seek help for it. Without recognizing and accepting the existence of a mental health problem, it is impossible for a youth or their family to request help from the service delivery system.

Youth and parents interviewed as part of this review indicated that failing to recognize there is a mental health problem can prevent youth from getting help. In some cases, a parent or caregiver recognizes that their child has a mental health problem but the youth refuses to allow them to seek an appointment with a professional because the youth feels he or she is “not crazy.” Parents and caregivers can be frustrated by this as their youth can be extremely ill and yet refuse to seek help.

In other cases, a youth recognizes he or she has a problem but does not feel comfortable discussing it with a parent and is uncertain where to get information or more formal help.

Informal Community Care

The second level of service is informal community care, which refers to the many community services that are important for supporting mental health but not designed specifically to respond to mental health problems. Schools in particular play an important role in identifying mental health problems and supporting youth and their families to access mental health services. Other examples include schools, police, youth drop-in centres and vocational programs. While this report focuses on specialized mental health services that respond to mental health problems and mental illness, the Representative recognizes the critical role that community services play in supporting mental health and the social and emotional development of youth.

Parents, caregivers and youth expressed mixed feelings about the ability of these informal services to identify mental health problems in youth and steer them in the right direction. In some cases, parents said they feel blamed for youths’ behaviour rather than having it understood as a symptom of a mental health problem.

In some cases, youth seeking support from school counsellors or youth workers at drop-in centres are advised and encouraged to seek more formal mental health care. Or a youth's behaviour can result in police involvement, which can lead to a judge ordering a mental health assessment and YFPS treatment if required.

However, in other cases, the mental health problem may not be recognized by informal community service providers. For example, a youth seeking support might be told to simply "shape up" rather than pointed toward a more formal mental health service.

Formal Services

The upper layers of the pyramid in Figure 6 consist of increasingly specialized formal mental health services – primary mental health care, community mental health services, services provided by general hospitals, long-stay facilities and specialized psychiatric services.

Primary Mental Health Services for Youth

Physicians who took part in the Representative's review indicated that the effectiveness of family doctors in addressing youths' mental health problems depends largely on the individual general practitioner involved. Some general practitioners can be very effective and do a lot to help youth receive specific mental health services while others don't feel properly trained to deal with mental health problems.

In some instances, a family doctor has sufficient training to treat the mental health issue and to monitor the condition, making further services unnecessary. In other cases, a family doctor assesses a youth's mental health problem, determines that more specialized care is required and refers the youth to community mental health services or a psychiatrist. However, some parents and caregivers said their family doctor wasn't properly trained to recognize and treat mental health problems.

Parent/Caregiver Voices

"The school system wore us out, summoning us to school to expel [our son], treated him and us as an annoying discipline problem, isolated him by sending him to different schools at a time when he needed inclusion."

"Schools can benefit from learning more about how to work with students who are experiencing anxiety."

Youth Voices

"I told [the physician] 'I'm having anxiety attacks for a little while, I've had some crazy ones,' and he's like 'OK, well here are the pills' ... I think it was easier for him to just prescribe me pills as opposed to finding out what the triggers are and, you know, referring me to someone or something."

Parent/Caregiver Voices

"GPs don't know where to send you."

Parent/Caregiver Voices

“Our family life might have been easier with any support service for our youth, but there was nothing. He was seen once by a child mental health therapist and told there was not enough of a problem to warrant receiving service, so we are just left on our own.”

“We were sent away from mental health [services] being told that [our son’s] case was too complex.”

“As the single parent of a child struggling with numerous complex problems and needs, I’ve spent the last five years trying desperately to find the services my child needs and they are not there.”

Youth Voices

“If there was no one there to take me [to treatment services], I probably never would have gone.”

Community Mental Health Services

Community mental health services are specialized services on the fourth tier of WHO’s pyramid, including assessment, treatment and referrals to other supports and services.

In general, parents and caregivers who participated in the Representative’s review expressed frustration with community mental health services. They spoke of long waits for youth before they could see someone. Some said youth can spend months on a wait list because their mental health problem is not considered severe enough to warrant immediate attention, with the youth’s situation eventually deteriorating to the point that they end up in a crisis. In some cases, youth can wait so long to see a clinician or psychiatrist that the crisis passes by the time they get in and the youth doesn’t present with any serious mental health concerns at the time of assessment although their problem is ongoing.

In some cases, after a long wait, a youth sees a psychiatrist, who prescribes medication and refers them back to their family doctor for ongoing support. But without their family doctor having sufficient training to monitor the medication and follow up effectively, these youth are sometimes left with inadequate support. Some parents and caregivers also told the Representative that, when they finally get in the door, services are not intensive enough to properly address a youth’s condition. The frequency of counselling services is sometimes inadequate to meet the needs of the youth and, as a result, many youth end up in crisis and, eventually, at a hospital ER.

A few parents relayed much more positive experiences with community mental health services, saying their youth received immediate assessment from CYMH when in crisis. Youth, parents and caregivers spoke highly of the EPI program.

But some youth said that they have challenges keeping appointments and getting to sessions, and that the way some services are delivered makes them reluctant to continue with those services. For example, a lack of flexibility in where and when services are provided can make accessibility difficult for youth.

Hospital Emergency Services

Parents and caregivers said that ERs are not set up to respond to mental health crises. Although they don’t want to take their child to the ER, they said there is nowhere else to go.

Parents also expressed frustration over their youth being discharged from ER, leaving them to manage the situation themselves until supports in the community are available. They spoke of their children, once stabilized in the ER, being sent home with no supports.

In some instances, youth are able to de-escalate from their crisis while in an ER and are successfully referred to CYMH. Some may be hospitalized as a result of their visit to the ER or admitted to the Child and Adolescent Psychiatric Emergency (CAPE) Unit at BC Children's Hospital.

Hospital Inpatient Services

Some parents and caregivers who took part in the Representative's review complained about their child not being placed in an appropriate inpatient unit when hospitalized. They expressed frustration and anger that hospitals are not appropriately set up to accommodate their children.

Parents, caregivers and physicians said it is inappropriate for a youth to be placed on a unit that is unresponsive to their age and maturity level. They gave examples of youth being traumatized after being placed in an adult psychiatric unit. Others informed the Representative about youth spending weeks on a pediatrics unit with limited mental health care capability.

Experiences with hospitalization ranged from youth stabilizing and being discharged with community mental health services in place, to other youth receiving little in the way of services upon release and returning to the ER after the next crisis.

Specialized Provincial Mental Health Facilities

The most specialized level of mental health care is delivered through two provincial mental health treatment facilities in the Lower Mainland and one on Galiano Island. The two Lower Mainland facilities are BC Children's Hospital in Vancouver, operated by the PHSA, and the Maples in Burnaby, operated by MCFD.

This specialized level of residential care is available in B.C. if a child is the right age, lives in the right community and there are open beds. Review participants said that even after receiving such specialized treatment, youth often end up back in the ER because there are not enough intensive community services to support them after discharge.

Some parents and caregivers said discharge planning in residential care can be unrealistic about what supports are actually available in a community. There may be no appropriate "step down" services available. Other families talked about their participation in post-discharge planning being limited.

Youth talked about forming important relationships when they were in residential care, only to have to leave those relationships and supports behind when discharged.

Parent/Caregiver Voices

"When you go to ER you're desperate. You go because someone is going to get injured. And then, when you get there, you have to lobby to get what you need. You must justify why you need help."

Youth Voices

"It's usually up to one person who does the right thing that can change your life, like the doctor who admitted me to the psych ward. Some doctors might have sent me away or asked me to come back in a few weeks, but she saw that I was in distress and that I could do better. And she kept me there."

Parent/Caregiver Voices

"Every time she was hospitalized or saw someone, there was no evaluation or follow-up."

Figure 7. Youth and Family Experiences When Accessing Mental Health Services in B.C.

The Representative has heard many stories from youth and families about navigating youth mental health services in B.C. Many expressed frustration with the system they encountered. While there is no “average” experience for youth and families with mental health services, the scenarios depicted here represent common themes in what youth and their families had to say.



Regardless of where youth and families are in the process of accessing mental health services, a number of things can happen, including:

- Youth has a mental health crisis and ends up in hospital Emergency Room
- Youth does not participate in a service for any number of reasons (e.g. does not recognize it is a mental health problem, mistrusts the system, mental health problem is too acute)
- The next level of care does not exist in the youth’s community
- There is a wait list to access services.

Self-Care

<p>Youth and/or family do not recognize that the youth may have a mental health problem. OUTCOME: No service accessed.</p>	<p>Parent/caregiver recognizes that the youth may have a mental health problem and wants to make an appointment with a family doctor or community CYMH. Youth refuses to go because he feels he’s “not crazy.” OUTCOME: No service accessed, returns to self-care without supports.</p>	<p>Parent/caregiver and youth both recognize that the youth may have a mental health problem. OUTCOME: An appointment made with a family doctor or health service.</p>	<p>Youth recognizes that they may have a problem but is not comfortable discussing with parents/caregivers. Is uncertain what the problem is, where to seek help, or how to get information. OUTCOME: No service accessed.</p>
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Informal Community Care*

(*Community services not designed to address mental health but are often one of the first providers to interact with youth with mental health problems)

<p>Youth seeks support but is told to just “shape up,” missing an opportunity to identify mental health problem. OUTCOME: Returns to self-care without supports.</p>	<p>Youth worker at drop-in centre sees that a youth is often struggling and lets this youth know that mental health counselling could help. OUTCOME: Appointment made with family doctor.</p>	<p>Youth’s “rebellious” behaviour results in police involvement. Youth is charged and judge orders a mental health assessment. OUTCOME: Assessment results in youth accessing specialized provincial facility.</p>
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Primary Care from General Practitioner

<p>Youth is identified with a mental health problem and family doctor has the training and support to treat it successfully. OUTCOME: With on-going monitoring from family doctor, no further services are necessary.</p>	<p>Youth has mental health problem and family doctor is not trained to recognize the issue. Family doctor tells youth what he is experiencing is “normal” at his age. OUTCOME: No service accessed.</p>	<p>Youth has mental health problem and family doctor or pediatrician does not feel able to treat it. Refers him to community mental health. OUTCOME: An appointment made with community mental health services.</p>
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Community Mental Health Services**

(**including MCFD CYMH and psychiatrists in private practice)

<p>Youth told problem is not serious enough for CYMH service. OUTCOME: Returns to self-care without supports.</p>	<p>Youth is on waitlist for services. OUTCOME: Returns to self-care without supports and waits, sometimes for months.</p>
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<p>After long wait, youth gets service from psychiatrist who prescribes medication and refers youth back to GP for ongoing support. GP does not have training to monitor medication and no follow up occurs. OUTCOME: Returns to self-care without supports.</p>	<p>Youth is in crisis and gets immediate assessment from CYMH. Receives service from Early Psychosis Intervention Program and gets coordinated support. Family involved in care planning and can support youth appropriately at home. OUTCOME: Transitions to adult services at 19.</p>
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Hospital Emergency (ER)

<p>Youth de-escalates from crisis in ER. There is limited mental health support at ER with no referral system in place. Family is not informed of youth’s mental health status or supports available in community. OUTCOME: Returns to self-care without supports after leaving ER.</p>	<p>Youth de-escalates from crisis. ER has referral system in place with CYMH and youth is referred to MCFD CYMH. Family informed of youth’s mental health status and is aware of referral to MCFD CYMH. OUTCOME: Goes to community mental health services.</p>	<p>Youth requires hospitalization. OUTCOME: Goes to inpatient hospital care.</p>	<p>Youth is fortunate to live near the only specialized psychiatric hospital emergency unit for children and youth in B.C. OUTCOME: Goes to specialized provincial facility.</p>
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Inpatient Hospital Care

<p>Youth spends days in Adolescent Psychiatric Unit. Discharge is planned with community services. Family involved in planning, understands how to best support youth at home. OUTCOME: Youth goes to community mental health services.</p>	<p>Youth is stabilized in hospital but needs intensive after care in community or specialized day treatment program. None available. Youth receives counselling support in community once a week. Family is not involved in care planning and has not been provided information to support youth’s mental health condition at home. OUTCOME: Youth’s mental health status deteriorates and youth returns to ER when another crisis occurs.</p>	<p>No Adult Psychiatric Unit in community. Youth spends weeks with physically ill infants on pediatrics ward with limited mental health care. Discharged without planning or referral, or services unavailable in community. With no planning and no information sharing, the family is unable to manage the youth’s mental health problem at home. OUTCOME: Youth’s mental health status deteriorates and youth returns to ER when another crisis occurs.</p>	<p>No space available in Adolescent Psychiatric Unit so youth is sent to Adult Psychiatric Unit (APU) instead. Youth traumatized by experience in Adult Psych Unit and requires further ongoing intensive support. OUTCOME: Youth referred to provincial specialized care facility. Usually has to wait for admission.</p>
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Specialized Provincial Mental Health Facility

<p>Before youth is discharged from provincial facility, planning takes place for return to community, but plan is unrealistic about available supports. OUTCOME: Returns to self-care without supports.</p>	<p>Following treatment, there is no appropriate “step down” service available. Some planning conducted with limited input from family. Youth returns to community services. But available services not appropriate for level of care required and family needs not supported. OUTCOME: Youth’s mental health status deteriorates and youth returns to ER when another crisis occurs.</p>	<p>Youth’s transition back to community is well planned and realistic, including considering the supports that family will require. OUTCOME: Returns to community mental health services.</p>	<p>Youth was referred to provincial facility but does not meet eligibility criteria because they are 18-years-old. Youth returns to community services, but available services not appropriate for level of care required. OUTCOME: Youth’s mental health status deteriorates and youth returns to ER when another crisis occurs.</p>
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Case Example

In early childhood, this girl began to have behaviour problems and later began to show signs of a significant mood disorder. At that time, a family history of mental health concerns was also identified.

A community-based psychologist was involved with the girl for many years. In her teen years, she was also diagnosed with conduct disorder. Although respite services were offered through MCFD, she was reluctant to attend.

At age 14, she was certified twice under the Mental Health Act and on both occasions was admitted to an APU located several hours away from her home community, for assessment and stabilization. The first time she was discharged from the APU, she was diagnosed with anxiety traits but was not prescribed medications.

The youth began receiving counselling from a community CYMH clinician after discharge. She began cutting herself and was placed on medication. She was monitored by a psychiatrist and a family physician in the community. She overdosed several times while on medication.

She was re-admitted to the APU less than 10 months after returning to the community. She was described as out of control and experiencing suicidal ideations.

After she was discharged the second time, APU staff noted that the youth continued to be at risk for suicide. APU staff also recommended that she should not return to her family home due to her violent behaviours.

Unfortunately, adequate planning did not take place before the youth left the APU. Her parents first contacted the Representative because they were concerned that their daughter was being discharged from the APU without a proper plan in place to ensure that she was safe and well supported in the community.

As a mental health residential resource was not available, she was eventually placed in an MCFD foster home. The foster home was not designed to provide intensive mental health supports. Efforts were made to ensure that she continued to receive CYMH counselling in the community over the long term.

The youth remained in foster care but was regularly absent from the foster home for extended periods of time and refused to attend counselling. She continued to have frequent episodes of suicidal ideation resulting in crisis responses from family, police and MCFD staff, which led to multiple emergency assessments at the local hospital.

Her parents struggle with the knowledge that their daughter continues to be at risk of suicide and that neither MCFD nor the health authority appear able to ensure that she is safe and participating in available mental health services.

Findings*

Finding:

Youth and their families experience too many barriers to mental health services, including a lack of understanding of mental health problems, long wait times and services that are not designed for youth.

Lack of Understanding of Mental Health Problems

Many participants in the Representative's focus groups and interviews said mental health problems in youth are not typically recognized as early as they could be. Youth, parents and caregivers cited their own lack of understanding of mental health as a barrier to getting help. Youth participants said that an experience of being stigmatized or labelled – and the fear that it might happen again – often kept them from seeking services.

Some youth admitted to having their own inaccurate stereotypes of mental health problems. Some said they considered people with mental health problems to be “crazy” and many did not want to think of themselves in that way or have others label them as such. Several youth feared stigma if others learned that they were getting mental health services – that *“people might know and think I am crazy.”*

Research shows that stigma regarding mental health problems is pervasive, and the need to reduce stigma has been identified by all jurisdictions reviewed for this report. *“Stigma refers to beliefs and attitudes about mental health problems and illnesses that lead to the negative stereotyping of people living with mental health problems and illnesses and to prejudice against them and their families. Stigma and discrimination have a huge negative impact on people living with mental health problems and illnesses, affecting all aspects and stages of their lives – dealings with friends, family, educators, employers and the health care system itself.”* (Mental Health Commission of Canada, 2009)

Research confirms that awareness of mental health problems and attitudes and reactions to mental health problems have a profound influence on youth's willingness and ability to access supportive services (Kelly, Jorm, & Wright, 2007). Stigma toward mental health problems can make youth and others unwilling to see problems for what they are and reluctant to seek support when they do recognize mental health problems (Mental Health Commission of Canada, 2009). As one youth who participated in this review said: *“When you start looking, you can find a whole other world for help, but if you're in denial, you don't seek it out.”*

* Note: All percentages reported in this section have been rounded to the nearest whole number.

Youth, parents and caregivers who participated also said that in some instances service providers – ranging from teachers and counsellors, to mental health practitioners and physicians – did not recognize youths' symptoms. They said it is important for service providers to be educated about mental health so that they can recognize problems and provide appropriate support.

One youth who was later diagnosed with multiple mental illnesses recalled asking for help from his school counsellor because he felt that he needed some guidance. The counsellor told him to *"Stop doing what you're doing,"* inferring that the youth had full control over his behaviour.

One parent responding to the Representative's survey commented that *"Instead of treating her [daughter's] mental illness, [service providers] said she was just a rebellious teenager."*

Parents and caregivers who participated in this review also described being blamed or judged for their children's behaviour by other parents as well as a variety of service providers. In some cases, parents and caregivers felt this blame or judgment was a result of stigma once others discovered that their children had mental health problems. But in other cases, they said these negative reactions occurred because people were simply unaware that a mental health problem could be the underlying cause of a behaviour.

Practice Example: Mental Health First Aid (www.mentalhealthfirstaid.ca)

An initiative of the Mental Health Commission of Canada, the Mental Health First Aid Canada (MHFA) program trains people to recognize the signs and symptoms of mental health problems, provide initial help and guide a person towards appropriate professional help. Available to members of the public, MHFA training can be helpful for many people, including families affected by mental health problems, teachers, health service providers and emergency workers. MHFA offers a basic course as well as a course specifically for adults who interact with youth that is designed to be sensitive to the unique aspects of mental health problems in young people.

Long Wait Times

Regardless of where they live in B.C., many youth seeking mental health services are put on waitlists because there are not enough services to meet demand. Those involved in the Representative's review consistently identified wait times as a significant barrier to services. Some youth spoke of being on wait lists of 12 months or more. Nearly 40 per cent of physicians indicated that waits of six months or more are typical for assessments by psychiatrists and CYMH clinicians [see Appendix C, Q1].

Long wait times for mental health services can result in deterioration of mental health and daily functioning, as well as, reduced motivation to seek services (Brown, Parker, & Godding, 2002). As one child and youth mental health practitioner said: *“There is a critical window to address illness. If you need to wait . . . you won’t do as well.”* Said one parent: *“We had to wait until my daughter became violent before even a semblance of help appeared.”*

Many who contributed to this review said that there is a serious shortage of child and adolescent psychiatrists in B.C. Depending on their training and comfort level, other physicians can sometimes provide services for youth with mild to moderate mental health problems, but child and adolescent psychiatrists are the most qualified to serve youth with complex mental health problems.

Youth, parents and caregivers can suffer the consequences of that shortage. One youth reported that when she was first referred by her family doctor to a psychiatrist, she was seen immediately. However, that psychiatrist moved away from her community and she was left without mental health support for six to nine months during a time when she was not stable.

One parent told the review that their son spent one year on a waiting list to see a psychiatrist after his previous pediatric psychiatrist retired. The parent felt this was “way too long” for the youth to go without his medications being monitored.

The shortage of psychiatrists can also result in youth who would benefit from their services not receiving them. In addition, it can contribute to delays in treatment provided by other mental health practitioners who can’t proceed without the youth first seeing a psychiatrist.

Practice Example: Rapid Access to Consultative Expertise (RACE) Phone Line for Child and Adolescent Psychiatry

The Rapid Access to Consultative Expertise (RACE) phone line for Child and Adolescent Psychiatry is a provincial resource available to family practitioners, pediatricians, adult psychiatrists and nurse practitioners from 8 a.m. to 5 p.m., Monday to Friday. Specialists accessed through RACE provide:

- *Timely guidance and advice regarding assessment, management and treatment of patients*
- *Assistance with plan of care*
- *Teaching opportunities – educational and practical advice*
- *Enhanced ability for family doctors to manage patients in their offices*
- *Calls returned within two hours and often within an hour*

MCFD Staff Voices

“We are experiencing referrals that are increasing in complexity and have a higher level of distress for the child and parents. Clinicians are challenged to balance between being able to provide longer-term therapeutic interventions that address complex, underlying issues and the need to end intervention in order to take on new cases on the wait list.”

“A current major challenge is the high demand for services that are leading to long waitlists with the concern for safety and the potential of increased severity for those on the waitlists.”

Youth Voices

Young people were able to identify mental health professionals who had been particularly helpful to them. These were people who:

- Treated them with respect
- Remembered them and what was going on in their lives
- Gave them positive feedback
- Asked questions and included them in decisions
- Did not stereotype
- Did not judge them for their substance use, but sought to understand the underlying mental health challenges that led to the substance use
- Helped them set and meet goals
- Offered some structure in their lives
- Included them in their diagnosis rather than just giving them a label
- Explained their diagnosis to them and what services and supports they could access
- Were flexible and creative
- Completed the tasks they promised to complete (e.g. made referrals)
- Took the time to build and engage in an ongoing relationship with youth
- Kept professional boundaries
- Acted as a positive role model
- Were knowledgeable about local resources and how to access them
- Did not treat them like a number

Mental Health Services not Youth-Friendly

Few mental health services in B.C. have been designed specifically for transition-age youth and the challenges they face aside from their mental health problems.

Youth participants said having a strong relationship with the person providing services is an important factor in their willingness to seek help. If they did not feel listened to, or if they felt judged by a service provider, they indicated they were less likely to seek services in the future. Said one youth: *"I'm not going back there again when I feel people don't listen or understand."* Some youth participants also spoke about feeling let down because personal connections with service providers were cut when service ended and the fear of that happening again kept them from seeking services going forward.

Some youth said they valued service providers who stuck with them regardless of their behaviour. However, some participants in this review expressed concern that other services use a "three-strikes-you're-out" rule that terminates service if a youth does not show up for a certain number of appointments. Said one child and youth mental health practitioner: *"There's a lack of understanding that these kids don't have the capacity to show up and manage their problems on their own. They need support."*

During the transition from adolescence to adulthood, youth also seek more independence, which affects how they typically engage with services. As one review participant indicated: *"They are less likely than children to want to admit that they have a problem and they have different relationships with their parents. Young children just show up at CYMH because their parents take them."*

The way traditional office-based services are delivered often limits the development of these important therapeutic relationships. Youth and other review participants said services should be offered in places that are easy for youth to access, including their homes, schools and drop-in centres. Services should be centrally located and offered during more convenient times, such as evenings and on weekends, they said.

The importance of using email, texts and phone calls to stay connected with youth was also noted by participants as a way to foster youth engagement. Said one physician: *"It's about having clinicians who are flexible. It requires people . . . to understand youths' needs supersede ours."*

Responses to the Representative's survey of MCFD staff suggest that some form of clinical community outreach exists in about half the province, with clinical outreach particularly strong in Aboriginal CYMH services [see Appendix C, Q2]. While some progress has been made in providing services in the home and community, more is needed to bring these services to youth with mental health problems across B.C.

Many review participants also called for more outreach to youth because, as one physician put it *“often the kids that need help the most aren’t the ones knocking on the door.”*

Youth indicated that it is important for service providers to address other needs in addition to their immediate mental health problems so that they are better able to engage in mental health services. These other needs centre around income, employment, and housing. Some youth spoke about the consequence of losing their housing if they used hospital inpatient or residential treatment services. Youth praised services that supported them in finding and maintaining housing and employment while also providing mental health treatment.

Practice Example: Inner City Youth Mental Health Program (ICYMHP)

The ICYMHP makes psychiatric services available to homeless youth where and when they need them, providing immediate on-site treatment for mental illness. A team of eight psychiatrists from St. Paul’s Hospital Psychiatric provides services at both locations of Covenant House, a non-profit organization serving homeless youth, as well as youth in 45 mental health housing units in partnership with Coast Mental Health, another non-profit. Coordinated by social workers from St. Paul’s Hospital and Covenant House, ICYMHP proactively addresses mental illness among homeless youth and helps them avoid hospitalization. In diagnosing mental illness and helping youth follow through with a treatment plan, ICYMHP plays a key role in preparing youth to access and manage housing for themselves.

Finding:

Mental health services are fragmented, difficult to navigate, and too often do not support and involve families in caring for youth who are experiencing mental health problems.

Research shows that family members typically provide the primary support for people living with mental health problems and illnesses. A 2004 interim report on mental health, mental illness and addiction to the Standing Senate Committee on Social Affairs, Science and Technology states that: *“it is parents who house, care, supervise and provide financial assistance to their affected children”* (Kirby & Keon, 2004a). And the Mental Health Commission of Canada recognized the principle that: *“family relationships play a unique role in promoting recovery and well-being, and protecting against the onset of mental illness”* (Mental Health Commission of Canada, 2009). This can be particularly true for youth ages 16 to 18 with mental health problems who generally live at home and rely on parents and caregivers to assist them with the necessities of daily life and the ongoing management of their mental health problems.

Key Participant Voices

“The key to working with youth is engaging them. We can only get them engaged if a relationship is established. This is not going to happen with a referral in the form of an appointment written on a card. Clinicians have to be out in the community.”

Physician Voices

“The assumption we make is ‘If we don’t hear from them, then they’re fine’ but, with kids, that’s not the case. They may be too paranoid to leave the home, too anxious to ride a bus to an appointment, in a room with lights off. I think it’s worth having a conversation around how do we make sure these kids stay healthy.”

Parent/Caregiver Voices

“My daughter has received wonderful care after I did cartwheels to get her in to see someone. I should not have had to fight that hard. This has been exhausting enough without the extra fighting. The lack of support and training for parents has been unreal to me. My daughter’s care would be much more successful if we were taught how to help her at home as well.”

Physician Voices

"I think there are very few things that are so stressful for family than a child who is psychiatrically ill – stigma, family functioning, future outcomes . . . it must be one of the highest levels of stresses there is. They are dealing with that 24/7, and they don't have the time to put into managing the system."

Youth who participated in the Representative's focus groups confirmed the important role that their parents and caregivers can play in supporting their mental well-being. Being in an environment with constant and consistent support and established rules and guidelines was identified as a key to good mental health. As one youth said: *"Being in a good environment and having positive people around you . . . that's what I need."*

Youth identified supportive parents and caregivers as essential in helping them to recognize and work through challenges in their lives and in advocating for them to get the mental health care they need. Youth spoke of the emotional support that family and friends provide, noting that they can play a particularly vital role when youth themselves are not able to recognize that they are ill.

Often, parents and caregivers find they are the sole resource for family members with a mental illness. Research shows that living with and being the main care provider for family members with a mental illness can be a source of tension, emotional stress and financial strain. Many jurisdictions around the world recognize the importance of assisting families in caring for family members with a mental health problem with initiatives to ensure the inclusion of families in each aspect of the planning and care delivery process (Child and Adolescent Mental Health Services, 2008; Council of Australian Governments, 2012; President's New Freedom Commission, 2003; The Mental Health Commission, 1998).

There is an overall recognition that *"interventions that only include the individual with mental illness are making only a partial response and therefore can only ever be partially effective. Fully effective interventions acknowledge and assess the needs of everyone affected by the illness"* (The Mental Health Commission, 1998).

The Mental Health Commission of Canada envisions a mental health system in which *"families have access to information, education, guidance and support through programs such as parenting support, peer support and respite care,"* and *"family members are partners in the recovery progress and integrated into decision making"* (Mental Health Commission of Canada, 2009, p. 16).

Difficulty Navigating the Mental Health System

Overwhelmingly, parents and caregivers who participated in this review found it difficult to navigate youth mental health services. More than two-thirds of parent and caregiver survey respondents disagreed or strongly disagreed that it is easy to find and access mental health services for their youth. Parents and caregivers from the focus group used terms such as *"scary," "confusing,"* and *"frustrating"* to describe the experience of navigating the mental health service system. Some characterized their experience as *"lonely"* and stated that *"navigation is a full-time job."* Some parents predicted they would struggle with figuring out mental health services throughout their children's lives [see Appendix C, Q3].

Child and youth mental health practitioners agree that it is difficult for parents to find and understand mental health services for youth. Said one practitioner: *"I still get confused, and I work in it."*

Parent/Caregiver Voices

"I consider myself to be fairly well educated and computer literate, but the hurdles I have to cross to get help for my daughter are unbelievable. I pity the parents who cannot navigate this system. It appears to me that it is purposely difficult to find the help that is available."

Practice Example: Centralized Intake

Nanaimo MCFD CYMH services have developed a centralized intake system to help children and youth and their families access the most appropriate mental health services for their needs in a timely manner. Intake clinicians receive all referrals requesting psychiatric services, complete intakes and, based on their assessment, provide information or referrals for community services, CYMH or the Vancouver Island Health Authority psychiatric team. Decisions about routing are made in conjunction with the VIHA child psychiatrist, pediatrician, and CYMH Team Leaders. The centralized intake has increased information sharing with referring physicians, decreased duplication of services, and is supporting families to access services within large systems.

Physician Voices

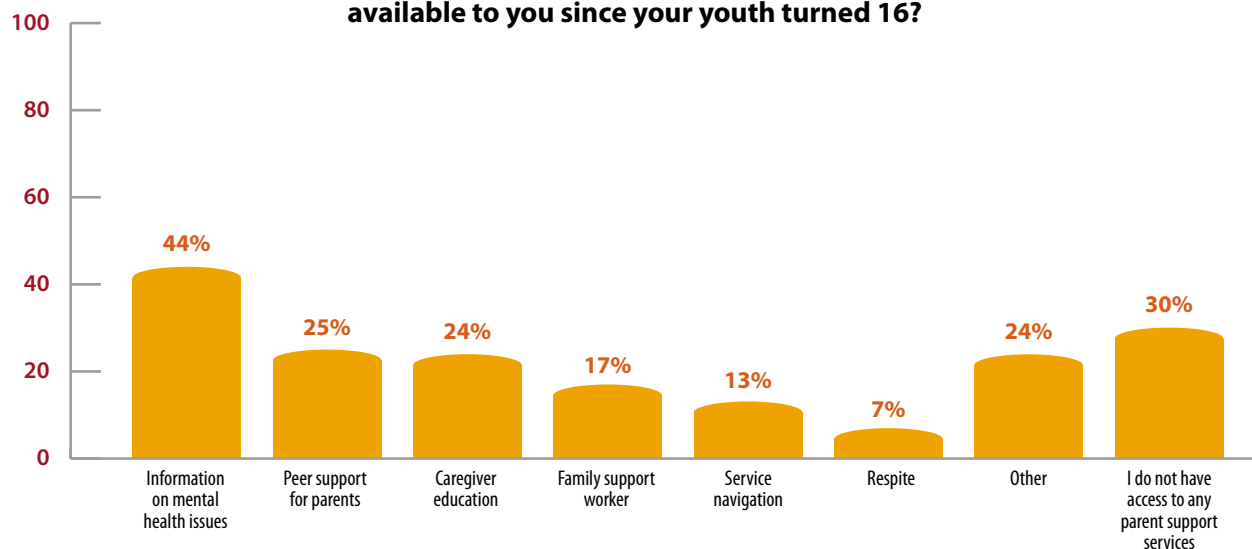
"I don't think our system is easy and I think it's challenging for people to get into the system. Those that have the ability to navigate can get in. Those that have challenges – it can be cultural, literacy, language challenges – it makes it challenging to get in."

Lack of Support for Parents and Caregivers

The B.C. government's 2003 five-year *Child and Youth Mental Health Plan* set clear expectations that parents would be supported and become central partners in the delivery of services. Some parents and caregivers indicated they were aware of and used existing web-based mental health information resources. However, many parents and caregivers said they still do not get the support they require to do so.

Parents and caregivers who took part in this review were asked to identify which services were actually available to them from a list of potential parent supports. For each of the services listed, fewer than 50 per cent of participants indicated that the service was available to them. "Information on mental health issues" was the most commonly selected support service with just 44 per cent of the parents and caregivers saying this information was available to them [see Appendix C, Q4].

Figure 8.
Parent and Caregiver Responses:
Which of the following parent support services have been available to you since your youth turned 16?



Parent/Caregiver Voices

Parents and caregivers identified the types of services and how they should be delivered to support them in caring for their youth. Parents and caregivers need:

- Proactive and timely response to youth's mental health problem before youth is in crisis
- Mental health system that recognizes parents and caregivers as equal partners in the planning and treatment of their youth's mental health needs
- Mental health professionals who value parents' and caregivers' insight and experiences with their youth's mental health problem
- Key informant or navigator who understands the mental health system and can help families to navigate the system
- Planned breaks for families who are caring for their youth with mental health problems
- Practical education on how to understand and manage their youth's mental illness
- Mental health professionals who proactively find a balance between involving families and respecting the youth's confidentiality

A number of parents and caregivers were either not offered services in their communities or were unaware of available services. About one-third of parents and caregivers indicated they did not have access to any parent support services. Parents and caregivers described their experiences with parent support services with comments such as "None offered!"; "Very little support available," "Would have been nice to have access to some support, but nothing was offered."

Parents and caregivers said respite services would be valuable for families with youth experiencing mental health problems. Despite the need for respite services being identified in government's 2003 five-year child and youth mental health plan, there is still no adequate respite for B.C. families.

Parents and caregivers also indicated they want practical education on mental illness to help them understand what their child is going through, as well as tips on how to manage mental illness. They indicated they want this information in an accessible, plain-language format without medical terminology or jargon. Youth echoed this desire for more relevant and available information on mental health for caregivers to make it easier for families to recognize signs of mental health challenges and problems.

Parents and caregivers also indicated that a "one-stop shop" for support services would be very useful. They said they were often left to piece together information on what services were available and how to access them. They indicated that having a single person to work with each family to help navigate the mental health system, get resources and assist in supporting their youth's illness would be beneficial.

Practice Example: Strengthening Families Together

Developed by the Schizophrenia Society of Canada, *Strengthening Families Together* grew out of the strong belief that Canadian families have a right to reliable educational information on serious mental illnesses, regardless of where they reside. This 10-session national education program for family members and friends of individuals with serious and persistent mental illnesses aims to increase accessibility to Canadian-based information on the topics associated with living daily with a mental illness. *Strengthening Families Together* is about more than education: it is about strengthening family members and friends of individuals with a serious mental illness by providing support, awareness and tools.

Lack of Parent and Caregiver Involvement

Some parents and caregivers who took part in focus group sessions saw themselves as the “*life-long case manager*” of their children, carrying the main responsibility of caring for their children and trying to manage their care and mental health needs. However, many parents and caregivers felt they were not meaningfully involved in planning for their youths’ care, and consequently were ill-prepared to support them at home.

The lack of parent and caregiver involvement in planning seems to be the result of a number of factors. In some cases, no planning occurs. In others, planning occurs but no one involves the family. In still others, there is a confidentiality issue and the youth requests that the parent or caregiver not be involved.

Unfortunately, child and youth mental health practitioner survey responses indicate that when planning occurs, supports that a family will need and input from parents and caregivers are not always considered [see Appendix C, Q5 & Q6]. Said one respondent: “*Most [mental health practitioners] remember to invite family. It’s the luck of the draw – you might get clinicians that value input and others that don’t talk to families at all. It is usually clinician-driven.*”

Some parents and caregivers also talked about a lack of connection between their experience and what the clinician sees. They felt that psychiatrists and clinicians make assessments and develop treatment options without consulting families to understand how the youth is functioning day-to-day or, as one child and youth mental health practitioner said: “*It’s like the behaviour in the office drives the treatment rather than the behaviour at home during the last week.*”

Parent and caregiver focus group participants felt that clinicians need to better recognize that parents and caregivers can be part of the team and offer further information to what the youth is providing, while still respecting the confidentiality of the youth.

Parent/Caregiver Voices

“I know she is struggling, and as a family we bear the burden of dealing with it, but we are kept in the dark about what issues she feels she has. She is very articulate and intelligent and, as such, is able to ascertain what she feels the worker wants to hear and will give different stories to different people. There is no ‘collaboration’ between parents, school counsellors, and mental health workers.”

Practice Example: Families Matter, A Framework for Family Mental Health in British Columbia

Funded by the government of B.C. and developed by the F.O.R.C.E. (Families Organized for Recognition and Care Equality) Society, the Families Matter framework is a planning resource for families, advocates, public policy makers and service providers. It is intended to guide the development and implementation of policies and services to promote family mental health, prevent and minimize family mental health challenges, and reduce the impact of mental illness on families across the life course and in diverse settings. This foundational document lays out a shared vision, values, key concepts, action guidelines, focus areas and intended results. Part of the goal of the framework is to help parents and caregivers get the support they need to cope and parent well despite their own or their children’s mental illness; to encourage mental health services to have a stronger family focus; and to assist individuals, families and communities increase control over their own mental health.

Finding:

There are significant gaps in the continuum of mental health services available to youth. The lack of crisis response services results in a revolving door through ER.

In B.C. there is a lack of community-based mental health care – care that is more intensive than existing CYMH services and less intensive than treatment on a hospital ward or specialized provincial mental health facility. Due to this gap, as well as a lack of primary mental health care, youth and their families in crisis rely on emergency services, which are often not set up to respond appropriately.

Youth interviewed for this review identified the hospital Emergency Room as the service they used most often to address their mental health needs. However, an ER is primarily designed to address acute physical ailments rather than a mental health crisis.

Lack of Specialized Emergency Mental Health Services

Most B.C. communities do not have specialized psychiatric emergency services for children and youth. Yet parents and caregivers who took part in this review indicated that they are told by child and youth mental health practitioners, physicians and police to take their youth to the hospital ER in the event of a mental health crisis.

Parents said that most ERs are not designed to meet the needs of youth with mental health problems. They also indicated that while youth are often treated or assessed for immediate mental health needs in an ER, they are also commonly released from ER back to their families without any supports or even referrals to community mental health services.

Services designed to respond to youth mental health emergencies should be an essential element of the overall youth mental health service system, according to MCFD's 2003 plan. However, most communities in B.C. do not have specialized psychiatric emergency services for children and youth.

Specialized services, such as the CAPE Unit at BC Children's Hospital, can provide youth with a jump start on assessment and treatment, mitigate their immediate risk and meet their immediate mental health needs. There is only one such unit in the province, located in Vancouver, and it only admits youth up to 16 years of age.

Mobile emergency mental health services are available in about half of the province and are concentrated in urban areas [see Appendix C, Q7]. These services consist of teams of professionals that can include psychiatric nurses, mental health clinicians, police officers and social workers that are usually available outside of office hours to travel to a person experiencing a mental health crisis. The team can provide assessment, intervention, referral and follow-up services.

These mobile emergency services are primarily concentrated in urban areas as many rural areas do not have large enough populations to support such specialized service. Even for areas that do have this service, it is not available 24 hours and police, who may not have the mental health training to provide appropriate support, often become the default response.

Practice Example: Providing Short-Stay, Inpatient Care

The Child and Adolescent Psychiatric Emergency Unit (CAPE) at BC Children's Hospital provides short-stay, inpatient care for children and youth through age 17 who are experiencing acute psychiatric problems on referral from community hospital emergency departments. CAPE is a six-bed unit staffed by registered nurses, child psychiatrists and social workers. CAPE is a model of a safe place for youth experiencing mental health emergencies to stabilize with appropriate supports. Child and youth mental health practitioners told the Representative that more such resources are needed in B.C.

Even if a youth lives in an area that provides specialized emergency services (such as CAPE or mobile emergency services), and is subsequently referred to community mental health services, the services available in the community often are not intensive enough to meet the needs of the youth following the crisis. A youth's condition can then deteriorate, which can result in a "revolving door" of the youth frequently requiring emergency services. For most youth in B.C., this means ending up back in the ER.

Case Example

Beginning at the age of 12, this girl's parents struggled to support their daughter through adolescence. During her late teens, she suffered from extreme anxiety and depression.

When the youth was about 16, she was severely injured as the result of a suicide attempt and her parents took her to the hospital ER. The hospital tended to the girl's significant physical injuries and she was summarily released. The staff told the girl and her parents that they would not be able to address her mental health needs, even though she was clearly mentally unstable.

The only option the hospital provided was to discharge her to her parents' care at home. As a result of the girl being discharged, her parents took her to another hospital with an APU where they lobbied aggressively, placing extreme pressure on the hospital to keep the youth until she was stabilized. The hospital finally agreed to admit her. She remained in hospital for three months before she was finally discharged.

Since that first incident at the hospital, the parents have taken their daughter to the ER approximately 15 times over three years and she has been admitted on about half of those occasions. In one instance in her mother's presence, the youth had a psychotic break, putting her life in extreme danger. Her behaviour at the time was extremely aggressive and unstable but the ER refused to assess her. Her mother had to ask a police officer for help while she quickly tracked down the youth's psychiatrist. Her psychiatrist directed the hospital to admit the girl immediately but, after seeing the on-call psychiatrist at the hospital, she wasn't admitted.

The youth's parents have found the experience of the ER when their daughter is having a mental health crisis to be very stigmatizing. They believe that they have been treated differently than other families and that ER staff blame them in some way for their daughter's mental health problems.

The parents believe that they provided strong family support to their daughter throughout her adolescence but that she required more support from the youth mental health system, particularly when dealing with crisis and emergency mental health situations. They also believe that their experiences would have been very different if the ER was better equipped to deal with youth mental health issues and if intensive, intermediate supports were available to address the treatment needs of youth when they leave hospital inpatient services and return to the community.

Lack of Community-based Intensive Intermediate Mental Health Care

Community-based intermediate mental health care – care that is more intensive than existing CYMH services and less intensive than treatment on a hospital ward or specialized provincial mental health facility – is virtually non-existent in B.C.

Services such as acute home-based treatment are a good example of more intensive supports that can be provided in the community to prevent youth from relapsing and ending up back in ER.

Practice Example: Acute Home Based Treatment Program

Vancouver Coastal Health's Acute Home Based Treatment (AHBT) service offers short-term, mental health treatment in home settings. This service is for people age 17 and older who are experiencing an increase in symptoms or distress related to mental illness or substance use. AHBT offers treatment in a comfortable, familiar environment with minimal disruption to day-to-day living, providing choice so that hospital care is not the only option. Treatment is coordinated with clients and their caregivers.

The 2008 progress review on MCFD's 2003 CYMH Plan found that the lack of intermediate care for adolescents with mental health problems – such as community residential treatment resources and day-treatment programs – was a serious concern.

In 2012, MCFD and the Federation of Community Social Services concluded a joint review of residential resources for children and youth in B.C., recommending investment in additional step-up/step-down intermediate residential care and treatment resources, including resources specifically for youth with serious mental disorders and concurrent mental health and substance use disorders. The Representative's February 2013 report *Who Protected Him?* also found a lack of appropriate residential care for young people with complex mental health needs.

The Representative finds that intermediate mental health care remains a pressing need. Responses from parents and caregivers, key participants and the survey of MCFD local service areas all identified the need for specialized mental health community residential treatment resources. As an MCFD local service area participant explained: *"A facility or staffed care home where a youth could continue to recover after an acute illness would be very supportive and would address the growing problem of increased hospital bed use."*

Lack of Primary Mental Health Care

Primary mental health care has an important place in the continuum of mental health services for youth. Family doctors are key to recognizing mental health problems early on, providing direct treatment or supports to youth with mild to moderate problems and providing referral, coordination and ongoing monitoring for youth who need to receive more specialized services.

Longer-term, on-going support that can be provided by family doctors is particularly important for youth with mental health problems. While these youth may be managing well during a given period, their problems often vary in intensity over time and some will develop into long-term, chronic conditions.

A youth with an emerging mental health problem, whose problem is identified early and who receives appropriate supports from a family doctor, can often avoid the problem getting worse and a crisis occurring. And following a crisis or discharge from hospital, a family doctor can be instrumental in monitoring youth to prevent a crisis from re-occurring.

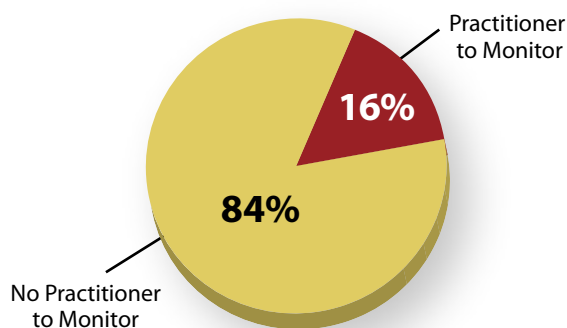
Unfortunately, there is a major service gap when it comes to primary mental health care for youth. As one key participant stated: *“There is no primary care system set up for mental health, as GPs are generally not well trained in mental health and there is no parallel mental health service.”*

The Representative’s surveys of child and youth mental health practitioners and community social service practitioners indicated that the on-going monitoring that should be part of primary health care is usually not there for youth with mental health problems.

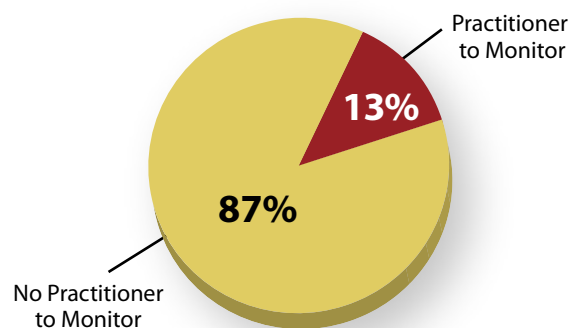
Overwhelmingly, these practitioners report that there is usually no practitioner designated to monitor a youth’s mental health status on an ongoing basis after he or she receives community mental health services [see Appendix C, Q8 & Q9]. Even in situations in which family doctors do take on a monitoring role, it is uncertain to what extent general practitioners are prepared for and supported to provide this role.

Figure 9.

Responses from Child and Youth Mental Health Practitioner Survey (n = 294)



Responses from Community Social Service Practitioner Survey (n = 70)



Feedback from review participants, including general practitioners as well as other physicians, shows that family doctors have varying comfort levels in identifying and responding to mental health problems. Limited training was identified as a barrier for family doctors in providing timely and appropriate mental health care. Said one parent: *“Our GP didn’t have enough training in mental health to recognize the seriousness of her issues.”* This perspective was echoed by a physician who said: *“There are varying comfort levels with mental health because [GPs] are not trained very well. The fact that approximately 80 per cent of mental health illness is manageable in primary care is news to doctors.”*

In addition to the limited training and few supports for serving patients with mental health problems, other barriers prevent physicians from effectively providing primary mental health care. Although recent changes to fee structures have supported family doctors in providing mental health care, some physicians who participated in this review indicated that fee structures still prevent them from providing appropriate mental health treatment and coordination with other service providers.

Physician Voices

“GPs have virtually no training in CYMH and are very anxious about taking something on and treating [with] psychopharmacology and they want support.”

Practice Example: BC Medical Association (BCMA)

Practice Support Program

The CYMH module of the BCMA Practice Support Program provides family doctors with the skills and knowledge to identify, diagnose, and treat anxiety and ADHD in both children and youth, and depression in adolescents, in the primary care setting. The aim of the module is to:

- *Improve access to mental health care.*
- *Address major gaps in care.*
- *Change the trajectory of conditions and potentially improve health outcomes for this vulnerable patient population – the earlier the detection, the better the treatment outcomes.*

The module also supports family and specialist physicians, school counsellors, and local child and youth mental health clinicians to work together to address mental health issues in youth. This is a joint initiative of the BC Medical Association and MoH.

Finding:

Information sharing and planning between hospital ERs, physicians, child and youth mental health practitioners and families is inadequate.

MCFD's policies and standards call for smooth and coordinated transitions, communication and planning for transfer of youth from one mental health service provider to another, as do policies of other agencies providing mental health services such as health authorities and hospitals. However, the reality on the ground is much different.

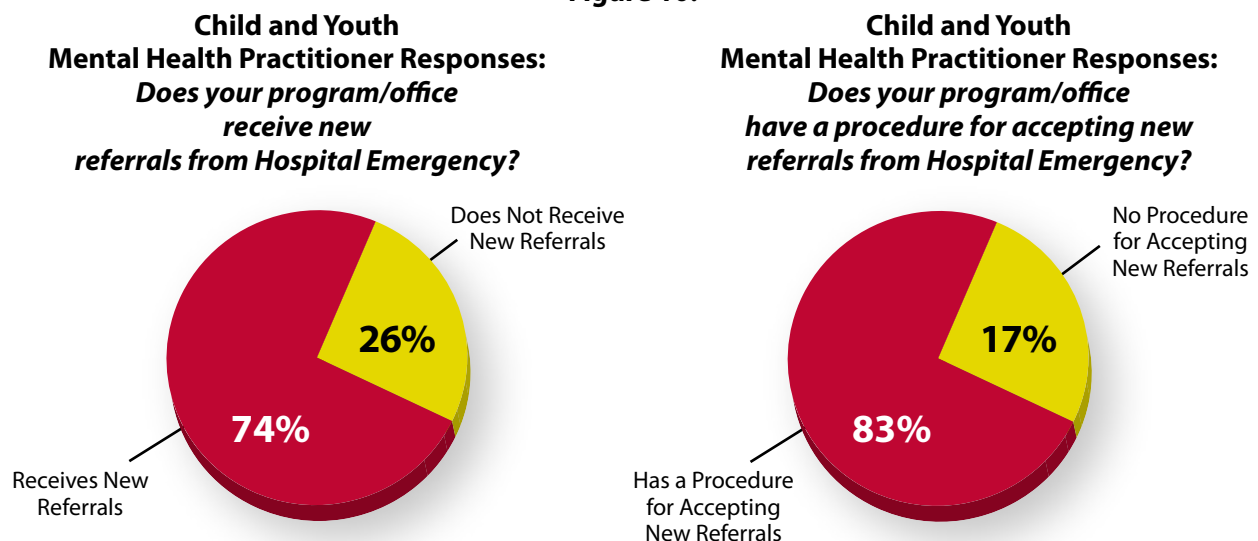
Child and youth mental health practitioners surveyed paint a picture of hit-and-miss transition for youth between services. Parents, caregivers and youth indicate they experience inconsistent levels of support through these transitions. And both child and youth mental health practitioners and physicians further point to a lack of communication and coordination when youth move between different services.

When youth experience gaps in mental health care as they move from one service to another, their mental health problems often worsen. Delays in treatment can result from inadequate information sharing or lack of coordination between services. If a new service provider does not know what treatments have already been tried, an unsuccessful treatment may be repeated. Meanwhile, youth and their families lose faith in services when the system does not support them.

Lack of Information Sharing from ER

MCFD's 2006 Mental Health Crisis Response policy calls for health authorities and regional MCFD offices to establish case management and client-tracking mechanisms to ensure the delivery of continuous and accountable care. Roughly three-quarters of all child and youth mental health practitioners surveyed indicated that their offices or programs receive new referrals from hospital ER's. The vast majority of child and youth mental health practitioners also indicated that their offices or programs have procedures for accepting these referrals [see Appendix C, Q10 & Q11].

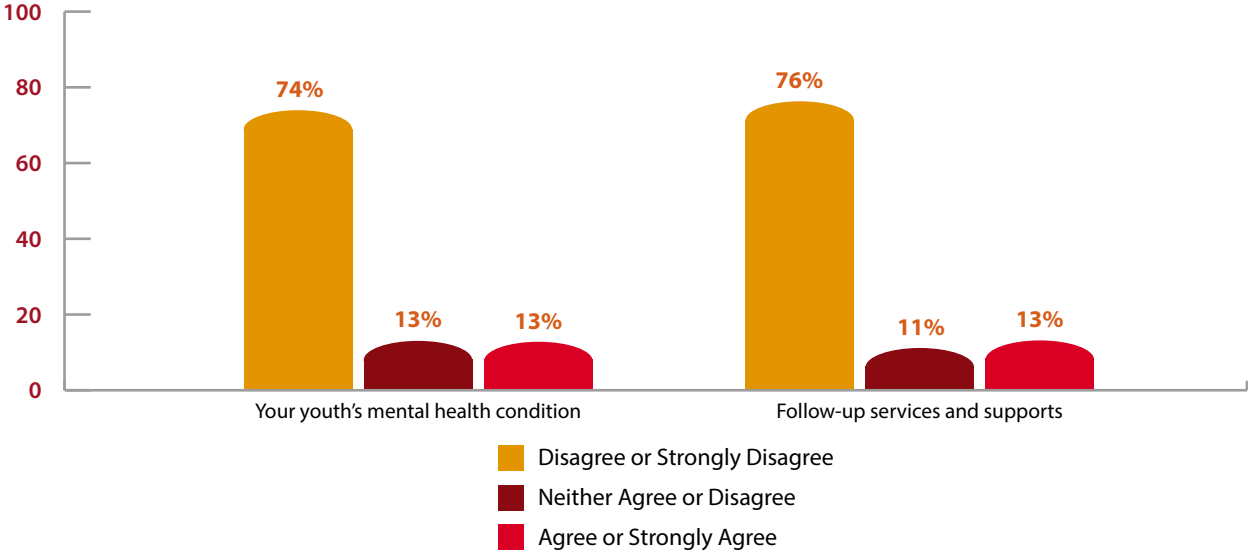
Figure 10.



However, despite procedures being in place, on average, child and youth mental health practitioners report they only receive information from the ER about half the time after a current client visits ER because of a mental health problem. This means that about half the time, some child and youth mental health practitioners receive no notification of the visit to ER, no assessment of the youth’s mental health condition at ER and no report on the visit’s outcome [see Appendix C, Q12].

Parents and caregivers who participated in the Representative’s survey and those who participated in focus group sessions shared similar experiences of leaving ER without information or support. About three-quarters of parents who responded to a question about visiting ER because of their youth’s mental health problem disagreed or strongly disagreed with the statement that before their youth left ER they had received information on their child’s mental health condition and on follow-up services and supports available in the community [see Appendix C, Q13].

Figure 11.
Parent and Caregiver Responses:
Do you agree or disagree that emergency staff gave you enough information on...



Physician Voices

"I don't know what they're [CYMH services] doing with my own patients."

"No information comes back to let me know if the patient has been assessed or put on a wait list."

Information Sharing with Physicians Inadequate

Physician survey responses show that, on average, child and youth mental health practitioners advise them about half the time of the results of mental health assessments for youth whom the physicians have referred. Physicians indicated that on average, they are seldom provided updates to the youths' current mental health status and treatment plans and are seldom advised when youth are no longer receiving community-based services [see Appendix C, Q14].

One physician had never received a treatment plan from CYMH for any of her patients. Another physician spoke about not receiving an action plan with clear expectations for the role of the family doctor – no clarity regarding the physician's role in monitoring medications and no communication about potential medication side effects or other considerations that the physician should be looking for.

One physician spoke with frustration about his experience with community-based mental health services: *"They don't want to know what I'm doing and they don't want to tell me what they're doing."*

These findings raise significant concerns about primary mental health care. Government's 2010 10-Year Mental Health Plan identifies family doctors as the foundation of primary mental health care. Physicians do not surrender their responsibility for a youth's care when they refer the youth to another service provider.

Physicians should receive assessment results, updates on the youth's mental health status, notification when the youth is no longer receiving the service in question, and a summary report on the youth's treatment when the service has ended. This information lets the physician know whether the youth is receiving or still requiring care, what type of care has been successful for the youth, and if any continuing care is required.

Planning Inadequate for Youth Leaving Hospitals and Residential Facilities

Planning for the transition of youth leaving hospital inpatient or residential treatment services to the community received mixed reviews. While 75 per cent of child and youth mental health practitioners said that planning usually or always takes place before a youth leaves such a facility, most youth, parents and caregivers had a different response [see Appendix C, Q15].

Although some youth did experience planning and had positive transitions, most could not recall any transition planning to support them in their return to the community. Many were able to remember feeling they had been discharged early and without any exit plan and they described this as a very negative and harmful experience. As one youth said: *"When you get out of treatment, you feel like an alien."* Youth who returned home to rural areas after a stay in hospital or other residential treatment programs said that no transition planning had occurred because there were no services or follow-up care available in their communities.

Few parents or caregivers were aware of a plan to support their youth in moving from a facility back into the community. Some said they had to insist that such a plan be created. One parent refused to take their child out of the hospital in order to force creation of a plan. Another parent spoke about the “*determination, repetition, will and anger*” she felt while trying to initiate planning. Some parents described being left alone to find access to community services, a role that best practice literature says should be done by professionals.

Several focus group parents and caregivers taking part in this review who were aware of a transition plan for their youth found that the plan was not realistic and not implemented when the transition actually took place. Such unrealistic plans likely result at least in part from a lack of consideration of the capacity of available community services. On average, child and youth mental health practitioners indicated that the ability of outpatient and community services to deliver planned services was only taken into account about half the time when planning occurred [see Appendix C, Q16].

Many parents echoed their children’s comments about receiving little support and having negative experiences when leaving inpatient or residential treatment facilities. Some parents said that, even when plans did exist, planned services were not available, there was sporadic or no follow-up after discharge, or poor communication between staff at the facility and community mental health services.

Survey responses from child and youth mental health practitioners indicate inconsistent practice in supporting youth through these transitions. On average, only about half the time does someone follow the youth until the transition is complete in order to monitor the status of the youth’s mental health condition during this period. Child and youth mental health practitioners also indicated that, on average, a break in service occurs about half the time when youth move from inpatient hospital services or residential treatment services to outpatient community mental health services [see Appendix C, Q17].

Responses from community social service practitioners were considerably less positive. They reported that it is common for youth to experience breaks in mental health service when they leave facilities and that youth often do not receive the treatment support they require in the community [see Appendix C, Q18].

Practice Example: Grand Rounds

The Adolescent Psychiatric Assessment Unit at the University Hospital of Northern British Columbia hosts weekly “grand rounds” via teleconference to support practitioners across northern B.C. who are working with youth with mental health problems, addictions and concurrent disorders. This meeting connects health authority, MCFD and contracted service providers, as well as teachers, and provides a place to call in to problem-solve, refer and plan treatment together. All service providers in the region are able to discuss at-risk youth with a larger multidisciplinary team, problem-solve ways to best provide support to the youth, and prioritize the inpatient waitlists.

In interviews and focus groups, child and youth mental health practitioners described some of the barriers to service coordination. Some said that success depends upon the individual clinician: *"It's personality-driven, it's not policy-driven. You can have the best policy in place, but it's up to people to develop those partnerships."* One mental health practitioner said: *"It always boils down to relationships with the individuals. Coordination fails when those relationships don't exist, when people move on or when people don't feel they have the authority to make decisions."*

Another practitioner spoke about communication difficulties between MCFD mental health practitioners and health authority mental health practitioners as an obstacle to planning: *"We don't use the same language or have the same perspectives. If they don't understand what a recommended therapy is or what our recovery model is, you have to do a lot more communicating to get a recommendation across."*

Some youth did give examples of positive support they received in their transition from inpatient or residential treatment services. Some said they benefited from information sharing between inpatient and community service providers, and some described having regular follow-ups after they left hospital. They believed this not only demonstrated that the professionals cared about them, but it also provided continuity for their mental health care. As one youth said: *"It's cool how they stick with you."* This, however, appears to be a sentiment that is not widely shared and reinforces that service provision and continuity are inconsistently available across British Columbia.

YFPS Services

Youth Forensic Psychiatric Services (YFPS) provide court-ordered and court-related assessment and treatment services for troubled youth. Inpatient and outpatient services are provided to youth in conflict with the law as well as those found unfit to stand trial or not criminally responsible due to a mental disorder. The Representative's Kids, Crime and Care report found that 72 per cent of children in care involved with the youth justice system were reported by the school system to have intensive behavioural problems or serious mental illness. This high prevalence underscores the importance of seamless, continuous care between YFPS and community mental health services.

When asked specifically about youth moving to and from YFPS services, child and youth mental health practitioners said that on average, transition discussions take place about half the time.

When a youth stops receiving YFPS services and is referred to child and youth mental health services for continuing support, on average, child and youth mental health practitioners receive information about the service provided by YFPS only about half the time. In contrast, information, on average, is usually shared when youth are moving from child and youth mental health services to YFPS services. This discrepancy in information sharing may be because YFPS assessments, which include gathering information about past services, are court-ordered and legally cannot be shared.

Survey responses also indicated that, on average, gaps in service happen for youth about half the time when moving from YFPS to other child and youth mental health services [see Appendix C].

Finding:

Existing services do not provide adequate capacity or clear mandates for addressing the mental health needs of transition-age youth.

Case Example

At age 16, this youth was placed in a hospital pediatrics ward for two weeks after a suicide attempt. She was considered too young to be admitted to the adult psychiatric unit and there was no adolescent psychiatric unit (APU) in the hospital. This was her sixth suicide attempt in a 12-month period.

While in hospital, she was referred to an APU located several hours away from her community. Unfortunately, she was placed on a wait list to access this APU and it was anticipated that she would not be admitted for at least two months.

Hospital staff had hoped that the youth would return to the care of her parents while waiting to be admitted to the APU even though she was unstable. She had been seeing a MCFD CYMH clinician in her community but her parents felt that they could not ensure her safety at home given her past suicide attempts and her stated intention to kill herself when she returned home. The youth was also deemed too high-risk by MCFD to be placed in a ministry foster placement.

She had not been certified under the Mental Health Act and ultimately chose to leave the hospital against her parents' wishes to live with a friend and her family while awaiting admission to the APU.

Without intensive, intermediate mental health supports available in the community, including an appropriate residential mental health care facility, the girl's parents were left with no alternative but to allow her to stay at her friend's home. Her parents continued to maintain primary responsibility for her care. An interim safety plan was developed and discussed with the girl, her parents and her support team. The psychiatrist that had treated the girl in hospital advised that he would not transfer her file to a community psychiatrist in order to provide continuity of service while awaiting further treatment at the APU.

Mental health service mandates in B.C. are based on chronological age and do not address the needs of transition-age youth. This is clear in both hospital and community services. In acute care in hospitals, youth find themselves between pediatric and adult services. And in the community, neither child and youth mental health services nor adult mental health services prioritize meeting the particular needs of this population. This is demonstrated in part by the lack of support provided to youth in their transition between these systems.

Acute Care Services not Designed for Transition-age Youth

Many B.C. youth do not have access to an adolescent psychiatric unit in their community. Instead, they may be admitted to other units, including general or pediatric units or adult psychiatric units. Parents and caregivers, physicians and other review participants voiced concern to the Representative about the lack of appropriate care provided to youth with mental health problems in these settings.

Physician Voices

"MCFD focuses most of their attention on [the] younger age group. Health authorities historically serve the 30-, 40-, 50-year-olds. Because of that, there is a huge gap for 16- to 24-year-olds. The greatest challenge is the group with the biggest need who are on the outskirts of each organization's mandate."

Physician Voices

“Placing young people with older people that are chronically unwell, in some ways, it’s like holding up a mirror.”

“The adult psychiatric unit at [the local hospital] is extremely reluctant in most cases to provide services to or to admit youth even when the situation is extremely urgent, other resources are unavailable, and older youth are presenting with significant and complex acute mental health concerns.”

Parent/Caregiver Voices

“My son was on a maternity ward for two weeks because a bed was not available on an adolescent psych unit in the next city. Nursing staff were not equipped to understand or deal with his issues nor did they want him on the unit. The programs/resources were not made available to him that would have been had he been on an adolescent psych unit i.e. peer group counselling, etc.”

Age-eligibility criteria for adolescent psychiatric units and specialized residential treatment facilities vary and, depending on where they live, 17- and 18-year-olds may not be eligible for services (see Table 2).

Table 2. Inpatient Adolescent Psychiatric Units and Specialized Residential Treatment Units (including age criteria and number of beds)

Facility and Unit	Age Criteria	# of Beds
Ledger House (Vancouver Island)		
• Special Unit	6-16 yrs	2
• Adolescent Unit	13-16 yrs	6
Kelowna Adolescent Psychiatric Unit (Interior)	12-17 yrs*	8
Surrey Adolescent Psychiatric Unit (Fraser)	13-18 yrs**	10
Prince George Adolescent Psychiatry Assessment Unit (North)	12-18 yrs	6
BC Children’s Hospital (Provincial)		
• Adolescent Psychiatric Unit	12-18 yrs	10
• Child and Adolescent Psychiatric Emergency Unit	5-16 yrs	6
Maples Adolescent Treatment Centre (Provincial)		
• Dala – assessment and intervention for youth with internalizing symptoms in relation to disorders of thought, mood or anxiety.	12-17 yrs	6
• Crossroads – treatment to youth with severe conduct and/or psychiatric disorders and assistance to their families and caregivers	12-17 yrs	7
• Response – development of care plans for youth with predominantly behavioural problems	12-17 yrs	6
Total # of Beds Across the Province		67

Note: These numbers were confirmed by respective health authorities and facilities as of February, 2013. The Representative had difficulty in ascertaining the age criteria for inpatient adolescent psychiatric units and specialized residential treatment facilities due to the inconsistency of the information available. Information on the age criteria listed on public websites often differed from information provided by individuals with whom the Representative consulted. In one instance, an organization listed different age criteria for the same service on two areas of its website.

* May consider 18-year-olds.

**May consider 12-year-olds.

Although BC Children’s Hospital is located in the Vancouver Coastal Health Region, its adolescent psychiatric beds are considered a provincial resource and available to all youth in the province. Vancouver Coastal Health Region does not itself have a dedicated Adolescent Psychiatric Unit.

There is one very specialized facility in the province designed to serve all transition-age youth, including 18-year-olds. Woodstone Residence is a provincial residential treatment centre for youth between the ages of 17 and 24 with eating disorders.

In B.C. hospitals where adolescent psychiatric units do not exist, adult psychiatric units may accept youth under the age of 19. However, in most of the province, the system of mental health inpatient hospital care does not recognize the needs of 18-year-olds, nor is it always flexible enough to fill the gap. For example, one parent who took part in the Representative's review indicated that their youth was denied a mental health service because they were *"too old for Ledger House, too young for acute adult care."*

Pediatric units are primarily designed to provide care for the physical needs of children, but may admit youth with mental health problems up to age 16 even if limited in capacity to deal with those problems.

Placing youth who are experiencing acute mental illnesses in a pediatric unit among children with physical health problems can compromise the dignity of the youth and create a disruptive environment for children on the ward. One parent who took part in the review said her youth spent 1 ½ weeks on a pediatric unit with *"babies, no peers. It was boring, unhelpful, and degrading."*

Physicians also informed the Representative of instances when they felt it necessary to lock down a pediatric unit to ensure the safety of a youth in the midst of a mental health crisis. They found the situation inappropriate both for the youth – who had no privacy during the episode – and the other children who had to witness the situation.

Youth are often equally out of place in adult psychiatric wards, where adult psychiatrists may feel unprepared to assess and treat adolescents. Time in adult psychiatric wards can heighten youths' anxiety and sense of isolation (Children's Commissioner for England, 2007), and exposure to adults with chronic and severe mental illness can also erode youths' hope for their own future well-being. In England, concern over youth being admitted to adult psychiatric facilities led to a legal duty to provide age appropriate hospital mental health care to minors admitted under that country's *Mental Health Act* (Care Quality Commission, 2012).

An MCFD staff member who participated in the review said finding inpatient services for youth ages 17 to 19 with a serious mental illness is a major challenge. *"Youth presenting with psychosis, serious suicidal ideation, or major mental illness where they are compromised and in need of admission to hospital, is a major issue."*

Pediatric units will often not accept such youth because of their behaviour and sometimes adult psychiatric units will not admit them due to safety concerns. These youth often present in a crisis, with hospital teams, community, and families having difficulty finding appropriate places to help stabilize them. The burden is often then placed on families and community teams to continue to monitor and support a youth actually in need of more intensive treatment and stabilization.

Services for Youth with Concurrent Mental Health and Substance Use Problems

Lack of service for youth with concurrent mental health and substance use problems was one of the concerns that led to this review of youth mental health services. Anecdotal evidence suggested that youth were caught in limbo when mental health services would not accept them until their substance use problems were addressed, and substance use services would not accept them until their mental health problems were addressed. Child and youth mental health practitioners and community social service practitioners indicate that having a substance use problem is a barrier to accessing mental health services about half the time. Survey responses from regional health authorities indicate that concurrent mental health and substance use treatment – providing treatment for both mental health and substance use problems at the same time – now exists in all 16 health service delivery areas in the province [see Appendix C].

Youth Not Well Supported in Transition to Adult Services

Case Example

During a three-year period many concerns had been raised about this youth's self-harming and aggressive behaviours at home and in the community. His mother and grandmother were his only family connections. His family had a history of mental health problems.

In late adolescence, the youth was diagnosed with a psychotic disorder and extreme anxiety. He began receiving psychiatric consultation and clinical support from MCFD CYMH services.

At age 17, he was placed in a MCFD group home because his mother was no longer able to manage him. An MCFD social worker was assigned to support him and continued that support until he turned 19. Workers believed that he was stable in his placement, managing his medications with support and was receptive to services.

Six months prior to his 19th birthday, the youth's care team, including his MCFD social worker and CYMH psychiatrist, began planning for his transition out of youth services and into Adult Mental Health services (AMH). This included exploring supportive adult residential options as the youth cannot live independently due to his mental health issues. Attempts were made to invite someone from AMH to attend transition planning meetings but without success.

When the youth turned 19, adult mental health supports were not in place – there was no mental health clinician or appropriate adult residential placement to support him. His care team was told that the only option available through AMH was a temporary placement in a hospital adult psychiatric unit. His care team felt that a placement in an adult psychiatric unit was not appropriate and might even be detrimental to his progress. Unfortunately given that the youth was now 19, he was no longer eligible for youth services or a placement in his current group home. With no other choices available, he was escorted by MCFD staff to a youth homeless shelter.

Most community mental health services for children and youth – including those funded and delivered by MCFD – will serve youth only until their 19th birthday. While primary mental health care from family doctors continues into adulthood, most youth with mental health problems who turn 19 can no longer receive services designed for children and youth.

Planning for the transition to the mental health services available for adults is inconsistent across the province. A few youth who participated in this review spoke about positive transition experiences when leaving child and youth services, but most could not remember any transition supports and felt left on their own to find their way to adult services. As one youth said: *“I was left at the edge of a cliff with nowhere to go.”*

Health authorities are the main providers of community mental health programs for people ages 19 and older, which are delivered through Adult Mental Health (AMH) services. These services are mainly for adults with persistent and severe mental illnesses.

Transition protocols between MCFD and health authorities call for youth who are receiving MCFD CYMH services and likely to qualify for AMH services to be identified, and for transition planning to be started on or about their 17th birthdays. These protocols say that effective planning must address housing, education, vocational, social and financial supports and treatment issues.

The Representative recognizes that this transition age is a critical period for youth with mental health problems. This is a prime developmental window in which to address mental health problems as well as other independence-related issues faced by youth, including housing, employment, income and education. The Representative notes with concern that not enough attention is being paid to this transition phase and that mental health practitioners in both the child/youth and adult streams are not collaborating sufficiently to support youth during this time.

Unfortunately, involvement in planning and information sharing to support youth moving between child and youth mental health services and adult services is inconsistent at best. Less than a quarter of AMH clinicians reported in surveys that they are usually or always involved in planning for these transitions before they take place [see Appendix C, Q19]. Only half of these clinicians indicated that they usually or always received information on youths’ mental health histories and current services and supports before starting services for youth transferring from child and youth mental health services [see Appendix C, Q20].

Despite the transition protocols between MCFD and health authorities, a comprehensive planning approach to supporting youth in transition is weak. Only about half of AMH clinicians indicated that planning before youth move from child and youth mental health services to AMH usually or always takes into account housing, financial and social support. And even fewer clinicians indicated that this planning usually or always takes into account vocational support or education [see Appendix C, Q21].

Youth Voices

“It’s like you’re supported and then, all of a sudden, the services are gone, and you’re like ‘What do I do now?’”

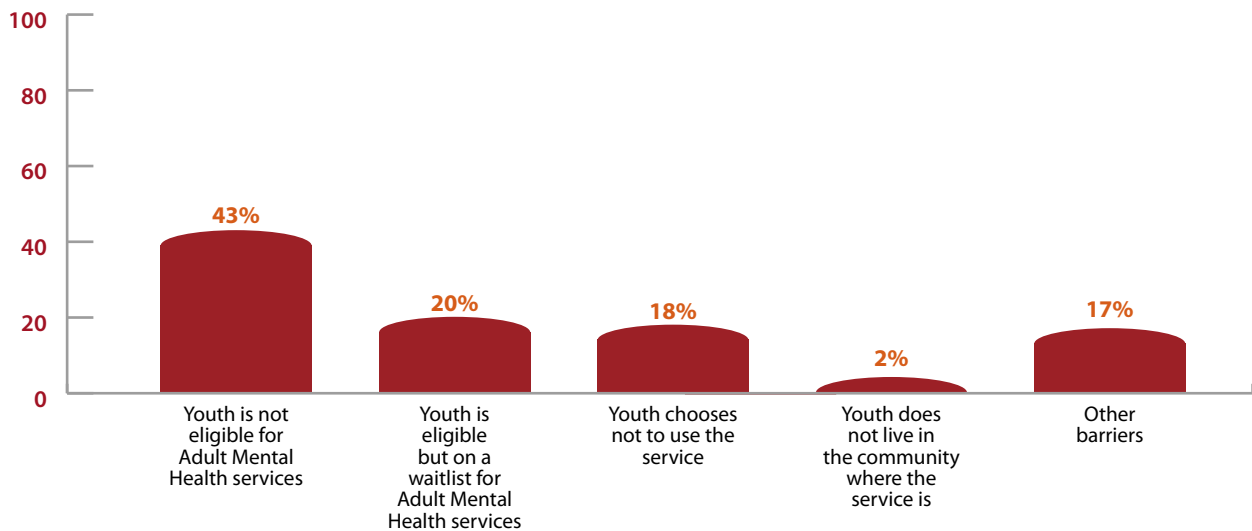
“When I was 19, they basically told me to ‘have a nice life.’”

When asked, child and youth mental health practitioners and AMH clinicians responded that not much is working well to support these transitions. One in five from both groups said that nothing is working well to support youths' transitions [see Appendix C, Q22 & Q23].

Responses to the survey of MCFD local service area staff described some of the difficulties in these transitions. *"We've had great difficulty in having youth actually picked up by the AMH team,"* said one respondent. *"They often wait for months in limbo."* Another indicated that referrals from CYMH to AMH are not formalized, creating barriers for youth transitioning into the adult system.

Surprisingly, this review found that eligibility criteria for AMH services often exclude youth, including those who have received CYMH services. In surveys, not meeting AMH eligibility criteria was identified most frequently by child and youth mental health practitioners as the most common barrier to youth receiving AMH services [see Appendix C, Q24].

Figure 12.
Child and Youth Mental Health Practitioner Responses:
What is the most common barrier to youth receiving Adult Mental Health services?



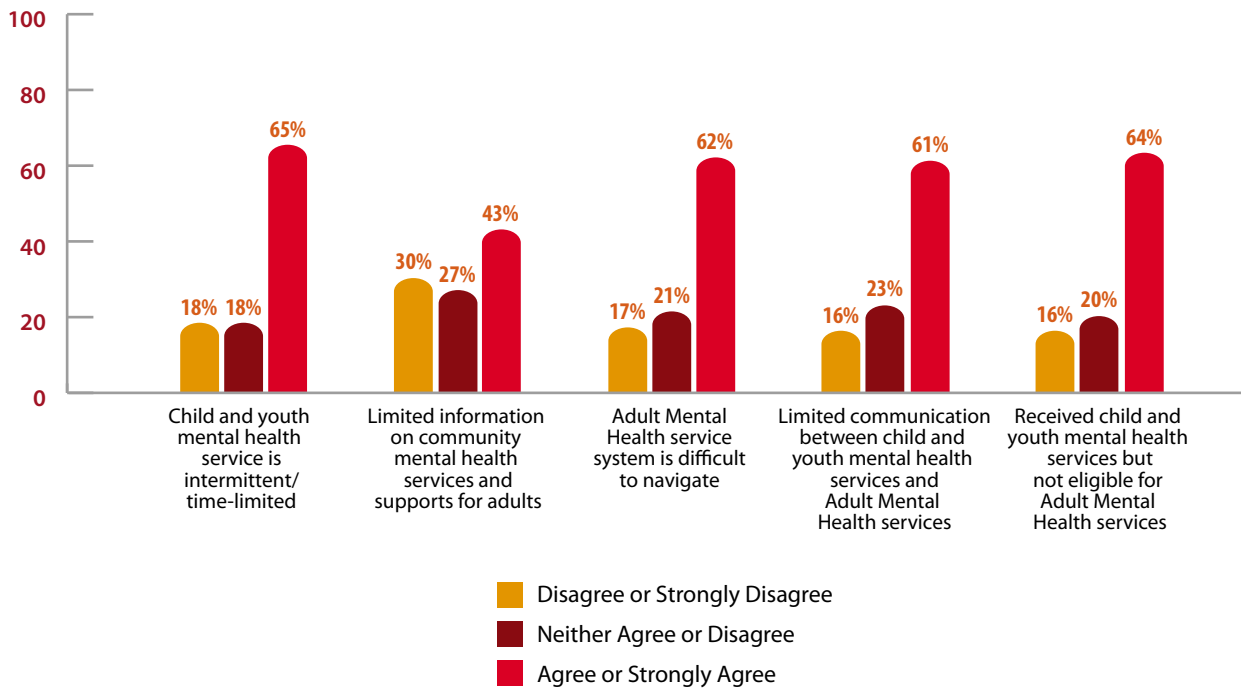
Many youth who have received CYMH services do not qualify for AMH services because their problems are not severe enough or their childhood disorders are not recognized in the AMH system. For example, youth with Attention-Deficit/Hyperactivity Disorder (ADD/ADHD) and behavioural disorders are much less likely to be eligible for AMH services than youth with other mental illnesses [see Appendix C, Q25 & Q26].

Survey results show that planning for youth to receive services after they turn 19 is inconsistent [see Appendix C, Q27-30]. A key barrier to planning for these services is the time-limited and intermittent nature of child and youth mental health services [see Appendix C, Q31]. CYMH practitioners are not usually involved in planning if a youth is not actively receiving CYMH services when planning should occur [see Appendix C, Q32]. Family doctors and pediatricians are not typically involved in such planning, either [see Appendix C, Q33]. Said one physician: *“Youth are not transitioned in this province. They’re forced to leap over a massive gap in services and most of them don’t make it.”*

Child and Youth Mental Health Practitioner Voices

“There is a major gap. The youth cohort do not get what they need. When you get old enough, then the adult world says you’re not chronic enough, you’re not sick enough for the adult system.”

Figure 13.
Child and Youth Mental Health Practitioner Responses:
Do you agree or disagree that the following reasons make it difficult to plan ahead for services that youth with mental health problems will require after turning 19?



Physician Voices

"If you look at age of onset for mental health disorders, the peak of onset is 16- to 25-years-old. And right in the middle of that, we say 'Okay, you're moving from the child system at 18 to the adult system.' What we see in CYMH in terms of teams and accessibility is very different than what we see in the adult system, and there are big breakdowns and kids get lost and you can't transition them."

The low level of involvement in planning reported for family doctors may be because some youth do not have family doctors, or because fee structures for general practitioners do not readily support their participation in planning meetings.

Many different types of service transitions occur simultaneously for youth with multiple needs, such as moving to adult mental health teams and hospital services, the end of MCFD involvement and support, and often the end of school involvement and support. Said one respondent to the survey of MCFD local service areas: *"This degree of change is often overwhelming and destabilizing for youth and families, who would benefit from having these changes occur in stages over a period of a few years rather than all at once."*

Finding:

There is a failure of provincial leadership and quality assurance for mental health services for youth.

Lack of Provincial Leadership for Youth Mental Health Services

Ten years ago, MCFD was viewed as a Canadian leader in child and youth mental health services when it developed the first plan for such services in Canada. The 2003 five-year CYMH plan included a continuum of mental health services for children and youth that were to be made available across the province. It also provided a road map to address key deficiencies in the system. This report was followed by an internal ministry evaluation in 2008, informing MCFD of the areas which remained problematic.

B.C.'s current 10-year mental health plan, *Healthy Minds, Healthy People*, is not specific to children and youth, it does not reflect most of the priorities of the 2003 CYMH plan nor does it specifically address any of the deficits pointed out by the 2008 internal review. The Representative's findings show long wait times, lack of family involvement and poor communication among service providers. Of particular concern are the gaps in community-based intermediate or step-up step-down care to provide intensive services. The lack of these services has led to chronic mental health problems being dealt with as crises in hospital ERs rather than through more appropriate community-based services.

A 2007 Auditor General's report and the internal 2008 review identified mental health leadership within MCFD as critical for implementing the 2003 plan and continued improvement of child and youth mental health services. The Auditor General actually cited concerns about MCFD's ability to maintain leadership in this area with the advent of a 2007 ministry re-organization.

The Representative's review found that removal of MCFD provincial leadership in the area of mental health meant loss of momentum and direction for child and youth mental health services. Not only did MCFD fail to create an overall coherent system of services for children and youth with mental health problems, it dismantled the internal system it had put in place to improve CYMH services.

Without dedicated CYMH provincial leadership and accountability mechanisms, MCFD regions have adopted a variety of management structures. When the Representative asked MCFD regions for service profiles, most regions did not have a single individual who understood the breadth of CYMH services available within the region or the working relationships with their corresponding health authority and other contracted service providers.

Program development, budget, service delivery and quality assurance decisions for CYMH services in the regions are often made by someone without any clinical mental health expertise – usually someone with a child protection background. Furthermore, there is no accountability to MCFD’s provincial office for these decisions.

Some policies to guide the work of community child and youth mental health services that were called for in MCFD’s 2006 standards, such as those relating to transition to and from hospitals and to adult services, have yet to be developed. There is no provincial oversight or accountability to determine whether regional policies and protocols to manage waitlists and improve coordination and collaboration among service providers have been implemented or how well that implementation has gone.

Despite the continuum of services described in the five-year CYMH plan, a single set of core services does not exist across the province. Each region, and in some cases each community, offers a different set of services. Where services may be similar, delivery mechanisms can differ. This lack of a cohesive service delivery system makes it incredibly difficult for parents, caregivers, physicians, community social services practitioners, and child and youth mental health practitioners to determine how to get help [see Appendix C, Q34-36]. While undertaking this review, the Representative also struggled to understand the many variations on the system of services for youth with mental health problems.

MoH also has the budget and responsibility for significant aspects of assessment and treatment for youth with mental health problems. The Representative finds it difficult to understand why there is no public reporting that provides a single, comprehensive view of how these health services are used and how effectively they are delivered. MoH’s annual reporting on the 10-year mental health plan often demonstrates piece-meal initiatives to dealing with issues that require a more comprehensive approach. A comprehensive approach can only be created through collaboration with the many organizations responsible for supporting youth with mental health problems. However, the Representative notes that this is not happening in a meaningful way for mental health services for youth. Although some health authorities and MCFD service delivery areas strive to work collaboratively together, both MCFD and MoH have not provided the leadership required to create a common culture of collaboration.

Although the 2003 CYMH plan called for improving coordination of planning and service delivery across ministries and sectors, there still seems to be no clear, mutual understanding of roles and responsibilities amongst the many service providers. During focus group and interview sessions, child and youth

Physician Voices

“If there is no continuity of care, at its most extreme, families implode. Youth leave home, sometimes end up on the street. Kids lose their lives. That’s at its most extreme. Behind that, we have kids that have all sorts of potential that they will never meet. We lose them – we lose them from our high schools, from our work force, from post-secondary education. That’s a real shame. The flip side of these [mental health] disorders is immense creativity and ability. So, when they are adequately supported, they are able to reach their potential and contribute in whatever way they were supposed to.”

“Managers are making decisions about care when they have no experience or understanding about the clinical ramifications of their decisions on the youth. And they have no idea how to manage a CYMH case load – that it is different than managing a child protection case load.”

Child and Youth Mental Health Practitioner Voices

“Trying to get the two organizations to come together on things is difficult. We’re out of synch. We don’t communicate the same things or come from the same perspectives.”

“Cultures and systems differ, and each side has misinformed expectations about the other.”

mental health practitioners from both health authorities and MCFD indicated that their counterparts did not understand their services. *“MCFD CYMH clinicians have a pretty clear understanding of HA youth mental health services – acute care and medical services. People working in the HA do not understand CYMH,”* said one MCFD practitioner. Health authority practitioners made comments such as *“MCFD lacks understanding that the APU is an assessment and short-term treatment option – not a placement option.”* Contracted service providers add a further layer of complexity.

Different organizations also mean different cultures and approaches to delivering mental health services for youth. Comments by review participants reflected a lack of understanding and value for other organizations’ approaches and contributions to address youth mental health needs.

There are also differing understandings of confidentiality, which can impact the effectiveness of information sharing. In discussions with physicians and child and youth mental health practitioners, it became clear that differences in information-sharing approaches were driven by organizational cultures, legislative mandates, professional backgrounds and standards as well as regulatory bodies. The different approaches to information sharing can leave professionals as well as parents and caregivers frustrated and poorly equipped to plan and care for youth with mental health problems.

Although MCFD has stated its intent to address some of the shortcomings within MCFD CYMH services, there is also a pressing need for a collaborative strategy to address the urgent inadequacies within the overall child and youth mental health system. The 10-year plan does not address most of the issues identified above. Resolving it will require leadership and commitment from MCFD, MoH and health authorities.

Practice Example: Early Psychosis Intervention

Early Psychosis Intervention (EPI) services are one of the few mental health services available to youth in B.C. that have been developed jointly between MCFD and MoH with specific standards and guidelines. These provincial standards and guidelines set expectations in areas such as response times to referrals, information sharing with referral sources, comprehensive required services including psychosocial rehabilitation services (i.e. vocational services) and recording of standardized key performance indicators for quality assurance purposes. EPI partners have access to an EPI Advanced Practice, developed and coordinated by Fraser Health (www.epitrainingbc.org), which include a web-based provincial training program, forums for networking and sharing resources and evaluation site reviews. As a result of this collaborative approach, there is a level of consistency in how EPI services are delivered, meet their clients range of needs and bridge youth and adult mental health services in B.C.

Inadequate Quality Assurance Activities

The siloed approach to delivering mental health services for transition-age youth means that multiple, disparate data systems are used to capture different types of client data. This data cannot easily be brought together to provide a comprehensive picture of which youth in B.C. are receiving what types of mental health services at what costs and with what outcomes. It is unclear how effective strategic policy decisions on mental health services for youth can be made without understanding the prevalence of various mental health disorders, utilization by service type, and re-admission rates.

MCFD is mandated with providing community mental health services to B.C.'s youth. But overall, the ministry provided insufficient data to determine the basic information requested for this review – including, simply, a specific count of the number of children and youth receiving publicly funded MCFD CYMH services in the province.

The ministry was also unable to provide other data, including an accurate count of youth in the transition-age group (16-24) currently waiting to see a clinician for MCFD CYMH services.

There is no central database that contains information about all youth who access publicly funded mental health services and no accurate picture of the number of youth who access the various different types of services. This is due, at least in part, to a lack of data coordination between MCFD, MoH and health authorities.

MCFD and MoH have not come together and developed agreed-upon quality metrics for youth mental health services to monitor and publicly report on. Therefore, there has been no coordinated, systematic analysis of the demand for and quality and effectiveness of these services in the province. Without regular integrated performance monitoring, there is not a robust understanding of what is working in the current system and what is not and it is impossible to set well-informed provincial goals and create comprehensive strategies to ensure that services as a whole meet the needs of youth with mental health problems.

The lack of coordinated quality-assurance activities for youth mental health services across the province means that no one is monitoring compliance with protocols, policies and standards. Although the Representative requested MCFD protocols with other service providers at the regional or local level, the number received was small and may not necessarily reflect the actual number of protocols in place. Even if protocols, policies and standards are being followed, it is not known if they are actually meeting their intended outcomes.

It was clear from conversations with child and youth mental health practitioners that the quality of planning and family involvement that occurs depends on the practices of individual practitioners rather than consistent quality assurance across the province. One child and youth mental health practitioner summed up what physicians, parents, caregivers and other practitioners continually stated about mental health services for youth: *“If you get good service, it’s all by luck rather than by design.”*

Recommendation

That the Government of B.C. 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. It is recommended that a new Minister of State for Youth Mental Health be created.

To support the work of this new minister of state, the following must be provided:

Detail:

- Adequate resources to develop and implement a full continuum of mental health services for youth ages 16 to 24.
- A senior official, no less than an associate deputy minister, reporting to the new minister of state. This official must have clear authority to lead a strategy spanning all other ministries, including MCFD, MoH, Education, Advanced Education and Social Development and to work collaboratively with professional and service-provider organizations. Clear direction must be given to respective deputy ministers that this is an urgent priority for government.
- The deputy minister of MCFD – as an interim measure – to prepare for the transition to a new minister of state.
- An external expert advisory council, including youth and family representation, to ensure that initiatives and strategies are clinically sound, responsive to youth mental health needs, and support an integrated, comprehensive approach to youth mental health.

Immediate tasks must include:

- Developing a detailed three-year operational plan to improve service delivery to youth across the spectrum, from acute care needs through to self-care supports. The plan should include immediate improvements to emergency, acute and community-based intensive intermediate care as well as youth-friendly service delivery models.

A draft form of this plan must be developed within six months of the appointment of the minister of state.

- Implementing a robust system of quality assurance, including performance measures and outcomes, and regular plain-language reporting to the public, decision-makers and service providers. Accurate integrated information will be required to ensure a cost-effective system.

A report on improved response and service levels must be provided to the Representative within 12 months of the appointment of the minister of state.

- Conducting an assessment of hospital acute care beds for transition-age youth in B.C. including a proposed plan to address unmet service needs.

A report on this assessment and plan to be provided to the Representative by Sept. 30, 2013.

Conclusion

This review points to shortcomings in the youth mental health system in B.C. as reflected through the experiences of both those who are served by the system and those who work in it.

These shortcomings are serious, and are also illustrated by the Representative's other work reviewing injuries and deaths of youth and advocating for individuals. Together, they point to the lack of a comprehensive, well-designed and efficiently delivered suite of mental health services for youth who are transitioning into adulthood.

In undertaking this review, the Representative found that mental health services for transition-age youth in B.C. are difficult to map and not easy to understand. Pathways for these youth through the system of services are not simple and are sometimes even traumatic, with some youth ending up in an adult psychiatric unit because there are no other suitable beds.

The Representative is concerned that important services – ranging from primary care to acute care and particularly community-based intensive immediate care – are difficult to obtain. There is no seamless system of supports, leaving many B.C. families struggling through difficult times, often with their son or daughter caught in the revolving door in and out of ER. Without proper supports, these families' relationships with their children can be jeopardized, and youth often feel abandoned and alone.

Long wait times for service are a major concern for families. The Representative notes that these wait times are the symptoms of a more serious problem – insufficient resources and a system that does not match real needs in the community.

More fundamentally, what we have learned is that there is a major task to be undertaken in B.C. Are we prepared to develop an effective collection of supports and services that truly functions as a system to meet the mental health needs of youth? Will we make the commitment to engage young people in building a youth-centered and family-focused system that provides all the necessary supports that youth require as they transition to independence? Or will we continue to make plans but few improvements on the ground, leaving youth and their families struggling to find their way to the support and professional help they need?

When mental health professionals are telling us that they cannot get the system to work, it should not be surprising that families and youth are frustrated, overwhelmed and sometimes willing to make their concerns public, thereby risking the privacy of their son or daughter. And there is a cost for these lost opportunities. We know that mental health problems often emerge in late adolescence and, left untreated, they can rob youth of their best chances in adulthood. We need to keep in mind the costs of not effectively supporting adolescent mental health, and these costs to families and society should be ever-present in our policy thinking and practice.

Our society is often not good at serving youth. Sometimes it is difficult to engage them in traditional services. It takes time and effort and sticking with it to serve and meet the needs of youth and their families. Traditional office-based practices do not always work with youth, and we are challenged to provide services differently – perhaps home-based, or after-hours, in schools or in other places they are more comfortable. The Representative advocates for the care and compassion these youth deserve, and the treatment that is their right. Too often, the Representative finds evidence that the youth justice system has become the outcome for youth whose needs have not been met by a robust system of preventative mental health and treatment programs.

The Representative acknowledges that we have had good, high-level mental health plans in B.C., but they are not enough. We have to move from high-level plans to actual service on the ground. And we have to know what is working for youth with mental health problems and their families and what is not. There is no clear single accountability for youth mental health in B.C. and no one ministry has responsibility for all direct services. Although a single point of management in the system is not possible, a single point of accountability with authority to compel collaboration is essential. An integrated and coordinated mental health service system for youth will not exist in B.C. until we drive change and service from one clear point of accountability and leadership.

Implementing the single recommendation made in this report will not be simple, or cost-neutral. The recommendation is to demonstrate our commitment to youth mental health by putting in place meaningful leadership and accountability to build the system on the ground, and report regularly on it. The current services are diffuse and complex, involving different government ministries, organizational structures, professional groups, payment mechanisms and interests, with little consistency across the province where youth reside. There are additional challenges associated with the diversity and geography of the province.

However, it is time for government to accept responsibility, to ensure that there is an effective and responsive mental health system for youth spanning the age range of 16 to 24 years during their transition to adulthood. It is time for government to treat this just as it would any other type of urgent health care need.

The Representative acknowledges that this task cannot be achieved overnight but immediate improvement can be made. The work must begin now, the resources must be provided and the effort must be sustained until the objective is achieved.

Glossary

Aboriginal Child and Youth Mental Health (CYMH) services: CYMH services for First Nations and Aboriginal children, youth and their families that are delivered or funded by Ministry of Children and Family Development (MCFD). These services include core CYMH service functions as well as approaches designed to respond specifically to First Nations and Aboriginal communities.

Acute care: short-term medical treatment for patients who are recovering from surgery or have an illness or injury with symptoms that have a rapid onset and a short duration. Acute care is usually provided in a hospital and includes emergency and inpatient care.

Acute home-based treatment: treatment in an individual's home that provides an alternative to hospitalization and provides support similar in intensity to what they would receive in hospital. This type of treatment can have added benefits of better engaging a patient's family and caregivers, and delivering treatment where the individual will be living when the service ends.

Adult Mental Health (AMH) services: community-based mental health services delivered by health authorities to people ages 19 and older. They mainly serve people with severe mental illness and offer case management and therapeutic programs.

Behavioural disorders: mental illnesses that primarily affect children and youth in terms of how they act or behave, and include the diagnoses of attention deficit hyperactivity disorder (ADHD), conduct disorder and oppositional defiant disorder.

Child and Youth Mental Health (CYMH) services: an MCFD program of mental health services for children and youth with mental health problems from birth to 18 years of age and their families. CYMH services include triage, resource and support services upon referral, mental health assessment, treatment planning, therapeutic interventions, and mental health consultation.

Child and youth mental health practitioners: professionals who provide or manage mental health services for children and youth through a variety of agencies. These practitioners include mental health clinicians who provide assessment and treatment, and outreach and support workers who provide other mental health services to children and youth with mental health problems.

Clinical outreach: service provided by a mental health clinician in settings such as homes, schools and community organizations that are outside of the traditional office environment.

Community mental health services: specialized services that respond to mental health problems and are delivered in the community rather than in hospital or provincial residential treatment facilities. In B.C., MCFD, health authorities, contracted service providers, pediatricians, and psychiatrists in private practice deliver publicly funded community mental health services to youth. Service delivery structures and services available vary considerably across the province.

Community-based residential treatment services/resources: specialized and long-term care for people with mental health problems in a residential setting within the community rather than in the individual's home. Treatment and management of mental health problems are integrated into residential supports.

Crisis stabilization: support that prevents a mental health crisis from getting worse and/or reduces immediate risk of harm to self or others.

Day treatment program: an intensive community-based program that provides daily services, usually in a group setting, to youth with serious mental health problems. Mental health treatment is provided along with other supports that usually include alternative education.

Developmental age: where an individual is in terms of his or her physical, emotional, social, and intellectual development when compared to the typical development of individuals of that chronological age.

DSM IV: The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association and provides the standard criteria used in North America for the classification of mental disorders. The current version is the DSM IV Text Revision, or DSM IV-TR.

Formal mental health services: services that are part of the system of specialized care for mental health problems and mental illness. Formal mental health services include primary mental health care, community mental health services, acute care provided in hospitals, and the most specialized mental health services and facilities.

Informal community care: community services that support mental health but are not designed to respond to mental health problems directly. These include schools, recreation programs, drop-in centres, and police.

Inpatient services: services that are provided to an individual who has been admitted to a hospital.

Intensive intermediate mental health services/Intensive intermediate care: community-based mental health services that provide more intensive support than weekly therapy, but are less intensive than the support provided in hospitals and in regional or provincial residential treatment programs. Intensive intermediate mental health services for youth can include day treatment programs that combine educational and/or vocational services with mental health services and community-based residential treatment services.

Key participant: mental health practitioners, policy makers and managers from MCFD (including Maples Adolescent Treatment Centre and Youth Forensic Psychiatric Services), MoH and health authorities, and physicians (e.g. pediatricians, family physicians and psychiatrists).

Mental health: a state of well-being in which the individual realizes his or her own abilities, copes with the normal stresses of life, works productively and contributes to his or her community. Good mental health is much more than the absence of mental illness – it enables people to experience life as meaningful and to be creative, productive members of society.

Mental health problem: a cluster of symptoms that causes distress and disrupts one's ability to function in important aspects of life. Mental health problems include those that may not meet the criteria for diagnosis as mental illnesses as well as those that do.

Mental illness/disorder: a mental health problem that meets the criteria for one of the mental disorders in the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Outpatient services: traditionally, services delivered by hospitals where patients visit without receiving acute care from an Emergency Room or being admitted to in-patient services. Some acute hospital-based levels of care, such as acute home-based treatment, are now delivered through outreach to youth in home and community settings.

Primary health care: a system that provides first contact access for each new health need, long-term person-focused care, comprehensive care for most health needs, and coordinated care when it must be sought elsewhere.

Primary classification: the main diagnosis of someone who is diagnosed with more than one mental illness.

Protocol: a formal agreement or understanding that guides how two or more organizations will work together when delivering services.

Respite: short-term, temporary breaks provided to families caring for youth with mental health problems in order to support and maintain the primary care-giving relationship.

Self-care: the act of caring for one's self and the care of family and friends. Mental health self-care takes many forms, such as managing stress, cultivating healthy relationships and keeping physically active. Other forms of self-care include seeking help when needed, engaging in planning for mental health services and participating in supports and treatment.

Step up/step down care: a form of intensive intermediate mental health care that is less intensive than hospital care but more supportive than many types of community mental health care. When these services are available, an individual with declining mental health can 'step-up' into a highly supportive environment in the community to prevent his or her mental health from deteriorating further and prevent the need for hospitalization. People who have received and no longer require hospitalization can 'step down' into this form of intermediate care to enable a gradual and supported return to the community, reducing the likelihood of readmission to hospital.

Stigma: beliefs and attitudes that lead to the negative stereotyping of people with certain attributes, circumstances or experiences and to prejudice against them and their families.

Transition-age youth: youth between the ages 16 to 24 inclusive who are transitioning between adolescence and adulthood.

Triage: a process in which a group of patients is sorted according to need for care.

Appendix A: Data Considerations

RCY Surveys, Focus Groups and Interviews

Responses from 853 participants of surveys, focus groups and interviews were used to understand how the system of services functions, how it is meant to function, and what might be done to improve the system to better support youth in B.C. Findings only reflect responses of youth, families, and service providers who have interacted with the public mental health system. The experiences of youth and families who have accessed private mental health services only or who have not accessed any supports and services may not be represented. Nevertheless, findings provide the most recent account of the experiences of youth and families with the publicly funded mental health service system in B.C., and identify specific areas that need to be addressed in order to better support youth with mental health problems in the province.

RCY was unable to obtain a fully diverse sample of youth with mental health problems for this project. Currently, there is no mechanism to gain access to a sample of youth that is representative of the diverse range of mental health problems they are experiencing. Furthermore, concerns about maintaining their confidentiality arise in the recruitment of youth who are currently (or were formerly) receiving treatment and support from child and youth mental health services. Identifying and contacting them would be a significant invasion of their privacy. For these reasons, RCY worked with McCreary Centre Society and researchers at Simon Fraser University in recruiting youth who were associated with organizations or previously known to these centres through past and current projects. As a result, the perspectives and experiences of youth described in the report may not be representative of all youth who would access mental health services in B.C.

Youth in the McCreary Centre Society sample who participated in the focus groups were connected to a mental health or other service provider, such as housing support services, at the time of their interviews. Several youth reported that they lived in various places when they were between the ages of 16 and 18 (e.g. parent's home, on the street, couch surfing, shelters, residential treatment programs, and foster homes). Youth in the Simon Fraser University sample were high-risk youth and many were involved with the youth justice system.

Common themes related to the key areas explored in this report were drawn from interviews and focus groups with youth, parents and caregivers, and key people working in the mental health service system. Responses from focus groups and interviews were compared to survey responses to provide an overall understanding of those key areas.

MCFD Administrative Data on Youth Accessing Mental Health Services

One aim of RCY's project was to understand the overall numbers and the profiles of youth who were currently accessing services from the publicly funded mental health service system in the province. As discussed earlier in the report, a central database that contains the information of all youth who access publicly funded mental health services in B.C. does not currently exist. Furthermore, there is not a single method of collecting and managing data on the utilization of mental health services by youth. For instance, the BC Medical Services Plan may collect data on patient visits with physicians working within private offices, and individual hospitals may collect data related to patient stays on hospital wards across the province. Both MCFD and the health authorities also collect and manage their own data on the child and youth mental health services that they each deliver. Due to these varying approaches to data collection and management, it was not possible to obtain all profiles and the exact number of youth who may be accessing publicly funded mental health services in B.C.

Given that a large proportion of child and youth mental health services were delivered by MCFD, it was possible to request information on the profiles of youth that this ministry served. MCFD collects and manages data on CYMH clients using two clinical tools. The Brief Child and Family Phone Interview (BCFPI) is an intake screening tool used to conduct a clinical screening for all CYMH clients. The Community and Residential Information System (CARIS) is a case management system for CYMH and acts as the client's primary legal clinical record. Demographic information on both BCFPI and CARIS tools are fully integrated. It is important to note that utilization of these clinical tools vary across MCFD CYMH offices. Moreover, CARIS is used across most MCFD CYMH offices, except by some of the contracted Aboriginal CYMH offices and CYMH offices within the Vancouver Coastal Health Authority. Information on clients served by MCFD CYMH offices within the Vancouver Coastal Health Authority is collected and managed by the health authority using the Primary Access Regional Information System (PARIS).

An initial request for data from both the BCFPI and CARIS tools was submitted to MCFD. MCFD informed RCY that some of these clinical tools (in particular the BCFPI) were not being used consistently by MCFD CYMH offices across the province, and profile information was not being captured for every youth who was accessing their services as a result. Accordingly, data on the profiles of youth being served by MCFD could only be extracted from CARIS as this system was used more consistently across the province in comparison to the BCFPI. Overall, the data provided did not reflect youth who were being served by most of the contracted Aboriginal CYMH offices and CYMH offices within the Vancouver Coastal Health Authority.

Appendix B: Data Collection and Participants

RCY and project partners collected data between March and December 2012. Participants, research tools, and data collection procedures are discussed by the topic areas explored in the report. A description of the participants and the number of responses received are presented in Table 1.

Availability of Services for Children and Youth with Mental Health Problems

Profiles on the services available for children and youth with mental health problems were collected from MCFD and health authorities. MCFD CYMH regional contacts were presented with a table consisting of a list of publicly funded child and youth mental health services. MCFD CYMH regional contacts indicated whether the services existed in the Local Service Area (LSA) and the age group that each service served. Similarly, regional contacts from each health authority (excluding the PHSA) were presented with a table consisting of a list of health services and programs for youth ages 16 to 18 with mental health problems. Regional contacts indicated whether the services existed in the Health Service Delivery Area (HSDA) and the age group that each service served.

Accessibility and Coordination of Services for Youth Ages 16 to 18

A combination of survey, focus group, and interview responses were used to assess the accessibility and coordination of services for youth ages 16 to 18.

Child and youth mental health practitioners, adult mental health clinicians, community social service practitioners, physicians, and parents and caregivers were invited to participate in a survey about mental health services for youth ages 16 to 18 in B.C. Email invitations were drafted by the Representative's Office and distributed by MCFD, health authorities, BC Children's Hospital, and community organizations¹ to their staff and members. Invitations included a link for participants to access and complete an online survey. Both online and paper surveys were available for parents, caregivers, and physicians to increase their participation.

Parents and caregivers of youth ages 16 to 24 with a mental health problem were also invited to participate in a focus group to share their experiences with the mental health service system. Invitations were drafted by RCY and distributed by the F.O.R.C.E. Society, the BC Canadian Mental Health Association, and MCFD CYMH offices in the North region through emails, announcements on the organizations' websites and/or in their newsletters. Focus groups were conducted in six communities across B.C.

¹ Community organizations included the Federation of Community Social Services of BC, BC Canadian Mental Health Association, the Canadian Academy of Child and Adolescent Psychiatrists, the BC Pediatric Society, the BC Medical Association, and the F.O.R.C.E. Society.

RCY worked in collaboration with the McCreary Centre Society and researchers at Simon Fraser University (SFU) to assess youths' experiences with the mental health service system:

- McCreary Centre Society invited youth (ages 16 to 25) to participate in focus group sessions across B.C. and to complete a paper survey about their experiences of mental health services (between the ages of 16 and 18) in B.C. Individual interviews were arranged for youth who preferred not to participate in a group setting.
- SFU researchers invited youth (ages 21 to 26) to participate in semi-structured interviews to share their retrospective experiences on the use of mental health services. Youth were drawn from a larger longitudinal project and were initially recruited when they were between the ages of 12 and 18 from custody centres, probation offices, and Maples Adolescent Treatment Centre, a provincial mental health centre in B.C.

Overview of the Mental Health Service System for Youth

RCY worked with MCFD, health authorities, BC Children's Hospital, the Canadian Academy of Child and Adolescent Psychiatrists, BC Pediatric Society, and the BC Medical Association to identify and conduct interviews and focus groups with mental health practitioners, policy makers and managers from MCFD, MoH, and health authorities, and physicians working in the mental health service system. Interview and focus group questions were developed to gain an overall understanding of the mental health service system for youth. Questions assessed the following: roles and responsibilities of service providers, communication and coordination between service providers across transitions (i.e. between youth services and between youth and adult services), what is working well and what are some of the challenges in the youth mental health service system, and suggestions for change.

Table 1. Description of Participants and Responses Received

Key Areas	Research Tools	Number of Participants/ Responses	Participant Description
A. Availability of Services for Children and Youth with Mental Health Problems	MCFD and Health Service Profiles	<ul style="list-style-type: none"> • MCFD Service Profiles received for 41 of 47 MCFD LSAs • Health Service Profiles received for all 16 HSDAs 	<ul style="list-style-type: none"> • Information was collected and compiled from staff across B.C. by four MCFD and seven health authority regional contacts
B. Accessibility and Coordination of Services for Youth Ages 16 to 18	Child and Youth Mental Health Practitioner Survey	<ul style="list-style-type: none"> • 338 child and youth mental health practitioners <ul style="list-style-type: none"> – 240 practitioners from MCFD (including Youth Forensic Psychiatric Services) – 98 practitioners from health authorities and BC Children’s Hospital (BCCH) 	<ul style="list-style-type: none"> • Child and youth mental health practitioners were: <ul style="list-style-type: none"> – MCFD practitioners who provided or managed mental health services for youth ages 16 to 18 – Health authority and BCCH practitioners who provided or managed mental health services for youth ages 16 to 18 in an in-patient or outpatient/ community setting • Child and youth mental health practitioners were mental health clinicians/ therapists, mental health service managers, youth forensics clinicians, physicians, or support workers
	Adult Mental Health Clinician Survey	<ul style="list-style-type: none"> • 82 adult mental health clinicians 	<ul style="list-style-type: none"> • Adult mental health clinicians worked in the community or outpatient settings in intake and screening, case management, therapeutic programs, general adult mental health services or specialized programs
	Community Social Service Practitioner Survey	<ul style="list-style-type: none"> • 91 community social service practitioners 	<ul style="list-style-type: none"> • Community social service practitioners worked in a community social service organization and also worked with youth (ages 16 to 18) with mental health problems in the areas of youth justice, addictions, mental health, child welfare, and educational/school services
	Physician Survey	<ul style="list-style-type: none"> • 85 physicians 	<ul style="list-style-type: none"> • Physicians consisted of pediatricians, general practitioners/family physicians, and child and adolescent psychiatrists

continued on next page

Key Areas	Research Tools	Number of Participants/ Responses	Participant Description
<p>B. Accessibility and Coordination of Services for Youth Ages 16 to 18 (continued from previous page)</p>	<p>Parent and Caregiver Survey</p>	<ul style="list-style-type: none"> • 94 parents/caregivers 	<ul style="list-style-type: none"> • Parents/caregivers were caring for a youth (ages 16 to 24) with a mental health problem • 67 per cent of parents/caregivers had a youth who was diagnosed with a mental disorder (e.g. mood, anxiety, ADD/ADHD or disruptive behaviour, or schizophrenia), and nine per cent were in progress of receiving a diagnosis
	<p>Parent and Caregiver Focus Group</p>	<ul style="list-style-type: none"> • 35 parents/caregivers from focus groups conducted in six communities across B.C. 	<ul style="list-style-type: none"> • Parents/caregivers were caring for at least one child or youth with a mental health problem • 89 per cent of parents/caregivers had a child or youth who was diagnosed with a mental disorder (e.g. depression, anxiety, ADHD, bipolar disorder, and borderline personality disorder)
	<p>Youth Survey, Focus Group, and Interview (McCreary Centre Society)</p>	<ul style="list-style-type: none"> • 70 youth ages 15 to 25 • Youth ages 15 were included to understand their experiences with mental health services, and to identify their needs and expectations of accessing services once they turned 16 	<ul style="list-style-type: none"> • Youth had experienced mental health challenges before the age of 19, and many youth were still facing on-going mental health concerns • Youth were connected to a mental health or other service provider (e.g. housing support)
	<p>Youth Interviews (Simon Fraser University)</p>	<ul style="list-style-type: none"> • 19 youth ages 21 to 26 	<ul style="list-style-type: none"> • Youth were diagnosed with at least three of the following disorders: conduct disorder, substance dependence, ADHD, depression, or PTSD
<p>C. Overview of the Mental Health Service System for Youth</p>	<p>Key Participant Interviews and Focus Groups</p>	<ul style="list-style-type: none"> • 39 key participants 	<ul style="list-style-type: none"> • Key participants were mental health practitioners, policy makers and managers from MCFD (including Maples Adolescent Treatment Centre and Youth Forensic Psychiatric Services), MoH, and health authorities, and physicians (e.g. pediatricians, family physicians, and psychiatrists)

Appendix C: Detailed Data Findings

Report findings were derived from a combination of information gathering tools. This appendix presents the data analysis of responses from two tools: 1) service availability information received from MCFD CYMH regional contacts and from each health authority, and 2) survey responses from child and youth mental health practitioners, AMH clinicians, community social service practitioners, physicians, parents, caregivers and youth. Survey findings in the report are presented as average responses and/or the per cent distribution of responses for each question. For some questions, participants were asked how often a situation or activity occurred. Reporting of the distribution of responses to these questions combines responses into two groups: one where responses indicated that a situation or activity happens never, seldom or about half the time, and another where a situation or activity happens usually or always. Survey participants were only asked to respond to questions that were applicable, and findings do not include incomplete responses or responses of “don’t know” or “not applicable” for each question. Therefore, the total number of participants used to calculate the average responses and the per cent distribution of responses varied for each question.

Results below are presented in the order they were discussed in the report’s findings section. Note that all percentages reported have been rounded to the nearest whole number.

Finding:

Youth and their families experience too many barriers to mental health services, including a lack of understanding of mental health problems, long wait times and services that are not designed for youth.

I. Lack of Understanding of Mental Health Problems

- This finding was derived from interview and focus group responses

II. Long Wait Times

Q1) [Physician Survey]

For youth (ages 16 to 18), what is the typical wait time from referral to mental health assessment by:

a. A psychiatrist

- Physicians who refer youth to a psychiatrist and could respond to this question (n = 75)
- On average, physicians reported that the typical wait time from referral to mental health assessment by a psychiatrist is about 3 to 6 months
- Responses are distributed as follows:
 - 21% of physicians indicated up to 3 months
 - 40% of physicians indicated 3 to 6 months
 - 21% of physicians indicated 6 to 12 months
 - 17% of physicians indicated 12 + months

b. Community child and youth mental health services

- Physicians who refer youth to community child and youth mental health services and could respond to this question (n = 80)
- On average, physicians reported that the typical wait time from referral to mental health assessment by community child and youth mental health services is about 3 to 6 months
- Responses are distributed as follows:
 - 21% of physicians indicated up to 3 months
 - 40% of physicians indicated 3 to 6 months
 - 28% of physicians indicated 6 to 12 months
 - 11% of physicians indicated 12 + months

III. Mental Health Services Not Youth-Friendly

Q2) [MCFD Service Profiles]

Does Clinical Community Outreach (i.e. street nurse, acute home-based treatment) exist in the Local Service Area (LSA)?

- MCFD regional contacts provided information for 40 out of 47 LSAs¹:
 - Interior – information received for 6 out of 9 LSAs
 - Coast Fraser – information received for 16 out of 20 LSAs
 - Vancouver Island – information received for all 10 LSAs
 - Northern – information received for all 8 LSAs

¹ MCFD regional contacts provided information for the Powell River/Central Coast LSA, but did not provide information for the Central Coast LSA. It is assumed that the information received for the Powell River/Central Coast LSA also includes information on the services being provided in the Central Coast LSA.

Table 2. Clinical Community Outreach across MCFD Local Service Areas

MCFD Region	Local Service Area (LSA)	Clinical Community Outreach Exists	Service Exists for Children and Youth Ages 6 to 18
Interior	North Okanagan Central Okanagan	Yes	Yes
	East Kootenay South Okanagan Shuswap Gold Trail	No	n/a
	Kootenay Boundary Kamloops Cariboo	Information was not received for LSAs	
Coast Fraser	Chilliwack Fraser/Cascades Surrey South Surrey East Vancouver Richmond North Shore/Squamish Sunshine Coast/Pemberton Powell River/Central Coast Central Coast Bella Coola Valley	Yes	Yes
	Abbotsford Mission Ridge Meadows Delta Vancouver North Vancouver South	No	n/a
	Burnaby/New Westminister Tri-Cities Surrey North Langley	Information was not received for LSAs	
Northern	Peace North	Yes	Yes
	Haida Gwaii/Rupert Terrace/Kitimat Bulkley/Stikine Quesnel Nechako Lakes Prince George Peace South	No	n/a
	Victoria Sooke/Westshore Peninsula/Gulf Islands Nanaimo Comox Valley	Yes	Yes
Vancouver Island	Duncan Port Alberni Parksville/Qualicum Campbell River Port Hardy	No	n/a

Finding:

Mental health services are fragmented, difficult to navigate, and too often do not support and involve families in caring for youth who are experiencing mental health problems.

I. Difficulty Navigating the Mental Health System

Q3) [Parent and Caregiver Survey]

**Please indicate how strongly you agree or disagree with the following statement:
It was easy to find and access mental health services for my youth**

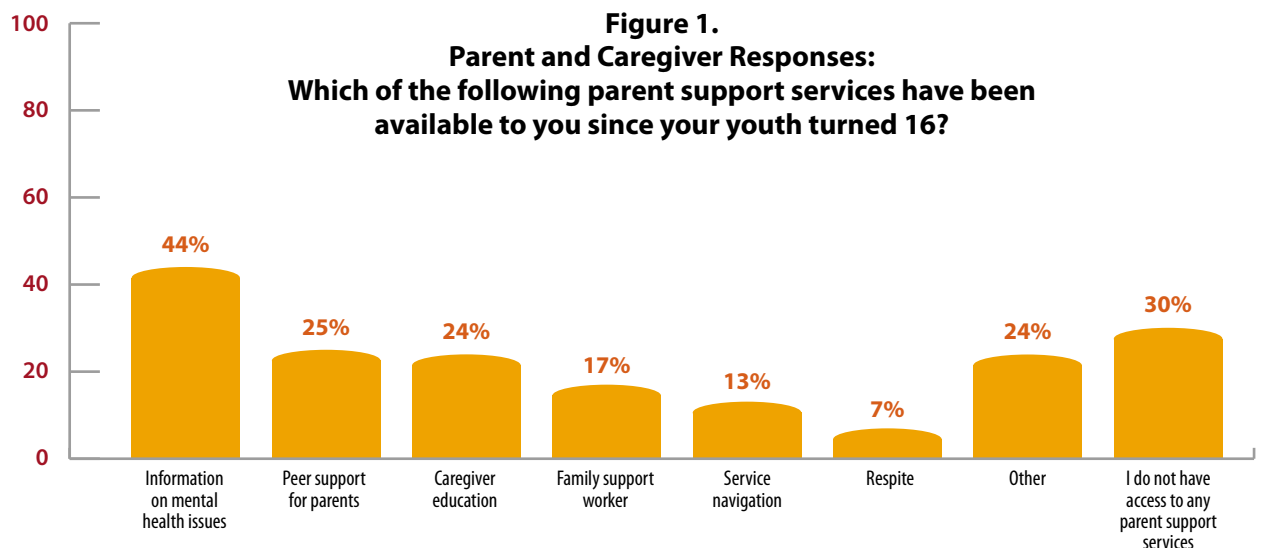
- Parents/caregivers who could respond to this question (n = 89)
- On average, parents/caregivers disagreed that it was easy to find and access mental health services for their youth
- Responses are distributed as follows: 69% of parents/caregivers disagreed or strongly disagreed that it was easy to find and access mental health services for their youth, 12% neither agreed nor disagreed, and 19% agreed or strongly agreed

II. Lack of Support for Parents and Caregivers

Q4) [Parent and Caregiver Survey]

Which of the following parent support services have been available to you since your youth turned 16? Mark all that apply.

- **Respite (e.g. your youth is in someone else’s care to give you a break)**
- **Service navigation (e.g. assistance in finding and accessing mental health services)**
- **Caregiver education (e.g. information on and strategies to manage your youth’s mental health problem)**
- **Peer support for parents**
- **Family support worker (e.g. in-home support such as coaching, mediation, counselling, planning)**
- **Information on mental health issues (e.g. educational materials, fact sheets, videos)**
- **Does not apply – I do not have access to any parent support services**
- **Other (specify)**



- Parents/caregivers who could respond to this question (n = 88)
- Responses are distributed as follows:
 - 44% of parents/caregivers selected information on mental health issues
 - 25% of parents/caregivers selected peer support for parents
 - 24% of parents/caregivers selected caregiver education
 - 17% of parents/caregivers selected family support worker
 - 13% of parents/caregivers selected service navigation
 - 7% of parents/caregivers selected respite
 - 24% of parents/caregivers specified other parent support services including support from service providers (e.g. psychiatrist, school counsellor), community groups (e.g. church youth program, the F.O.R.C.E. Society), and friends and coworkers. In contrast, some parents indicated there was very little to no support offered to them
 - 30% of parents/caregivers selected that they do not have access to any parent support services

III. Lack of Parent and Caregiver Involvement

Q5) [Child and Youth Mental Health Practitioner Survey]

When transition planning occurs for a youth's move from an inpatient/residential treatment facility to outpatient/community mental health services, how often does transition planning take into account support that the family will need to care for the youth?

- Child and youth mental health practitioners who could respond to this question (n = 269)
- On average, child and youth mental health practitioners indicated that discussions usually take into account the support that the family will need to care for the youth
- Responses are distributed as follows: 59% of child and youth mental health practitioners indicated usually or always, and 41% indicated never, seldom, or about half the time

Q6) [Child and Youth Mental Health Practitioner Survey]

When discussions take place before a youth (ages 16 to 18) moves between mental health services, how often do discussions among current and new service providers include input from parents/caregivers?

- Child and youth mental health practitioners who could respond to this question (n = 313)
- On average, child and youth mental health practitioners indicated that discussions among current and new service providers usually include input from parents/caregivers
- Responses are distributed as follows: 59% of child and youth mental health practitioners indicated usually or always, and 41% indicated never, seldom, or about half the time

Finding:

There are significant gaps in the continuum of mental health services available to youth. The lack of crisis response services results in a revolving door through ER.

I. Lack of Specialized Emergency Mental Health Services**Q7) [MCFD Service Profiles]**

Does Mobile Emergency Mental Health Service (crisis response) exist in the Local Service Area (LSA)?

- MCFD regional contacts provided information for 38 out of 47 LSAs²:
 - Interior – information received for 6 out of 9 LSAs
 - Coast Fraser – information received for 14 out of 20 LSAs
 - Vancouver Island – information received for all 10 LSAs
 - Northern – information received for all 8 LSAs

² MCFD regional contacts provided information for the Powell River/Central Coast LSA, but did not provide information for the Central Coast LSA. It is assumed that the information received for the Powell River/Central Coast LSA also includes information on the services being provided in the Central Coast LSA.

Table 3. Mobile Emergency Mental Health Services across MCFD Local Service Areas

MCFD Region	Local Service Area (LSA)	Mobile Emergency Mental Health Service Exists	Service Exists for Children and Youth Ages 6 to 18
Interior	North Okanagan Central Okanagan	Yes	Yes
	East Kootenay South Okanagan Shuswap Gold Trail	No	n/a
	Kootenay Boundary Kamloops Cariboo	Information was not received for LSAs	
Coast Fraser	Abbotsford Chilliwack Mission Fraser/Cascades Tri-Cities Surrey South Delta Vancouver Richmond Vancouver North Vancouver South	Yes	Yes
	Ridge Meadows North Shore/Squamish Sunshine Coast/Pemberton Bella Coola Valley	No	n/a
	Burnaby/New Westminister Langley Surrey North Surrey East Powell River/Central Coast Central Coast	Information was not received for LSAs	
Northern	Peace North	Yes	Yes
	Haida Gwaii/Rupert Terrace/Kitimat Bulkley/Stikine Quesnel Nechako Lakes Prince George Peace South	No	n/a
Vancouver Island	Victoria Sooke/Westshore Pennisula/Gulf Islands Nanaimo Parksville/Qualicum Comox Valley	Yes	Yes
	Duncan Port Alberni Campbell River Port Hardy	No	n/a

II. Lack of Community-based Intensive Intermediate Mental Health Care

- This finding was derived from interview and focus group responses

III. Lack of Primary Mental Health Care

Q8) [Child and Youth Mental Health Practitioner Survey]

For youth (ages 16 to 18) who have accessed mental health services but no longer require active support, is there usually a practitioner designated to monitor the youth’s mental health status on an ongoing basis?

- Child and youth mental health practitioners who could respond to this question (n = 294)
- Approximately 84% of child and youth mental health practitioners indicated that there usually is no practitioner designated to monitor the youth’s mental health status on an ongoing basis
- About 16% of child and youth mental health practitioners reported that there is usually a practitioner designated to monitor the youth’s mental health status on an ongoing basis

Q9) [Community Social Service Practitioner Survey]

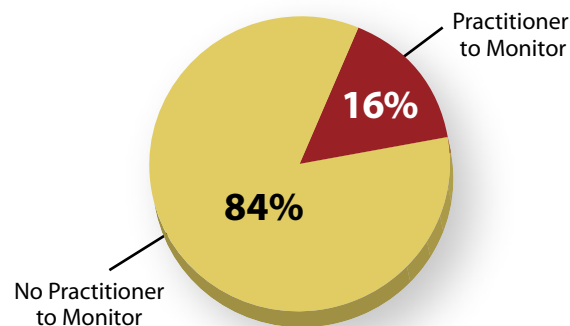
For youth (ages 16 to 18) who have accessed mental health services but no longer require active support, is there usually a practitioner designated to monitor the youth’s mental health status on an ongoing basis?

- Community social service practitioners who could respond to this question (n = 70)
- Approximately 87% of community social service practitioners indicated that there usually is no practitioner designated to monitor the youth’s mental health status on an ongoing basis
- About 13% of community social service practitioners reported that there is usually a practitioner designated to monitor the youth’s mental health status on an ongoing basis

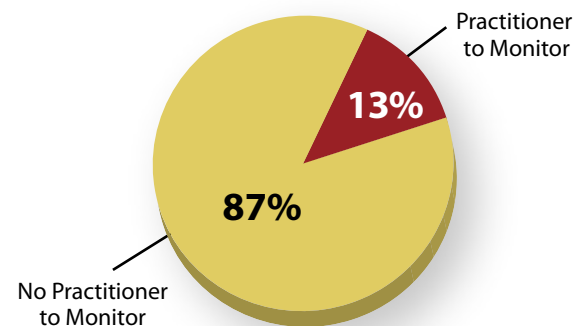
Figure 2.

For youth (ages 16 to 18) who have accessed mental health services but no longer require active support, is there usually a practitioner designated to monitor the youth’s mental health status on an ongoing basis?

Responses from Child and Youth Mental Health Practitioner Survey (n = 294)



Responses from Community Social Service Practitioner Survey (n = 70)



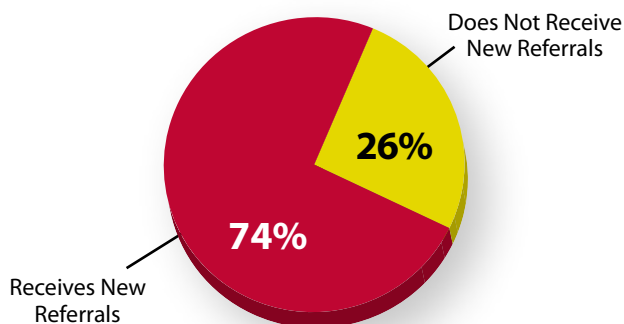
Finding:

Information sharing and planning between hospital ERs, physicians, child and youth mental health practitioners and families is inadequate.

I. Lack of Information Sharing from ER**Q10) [Child and Youth Mental Health Practitioner Survey]****Does your program/office receive new referrals from Hospital Emergency?**

- Child and youth mental health practitioners who could respond to this question (n = 257)
- Approximately 74% of child and youth mental health practitioners indicated that their program/office receives new referrals from Hospital Emergency
- On the other hand, about 26% of child and youth mental health practitioners reported that their program/office does not receive new referrals from Hospital Emergency

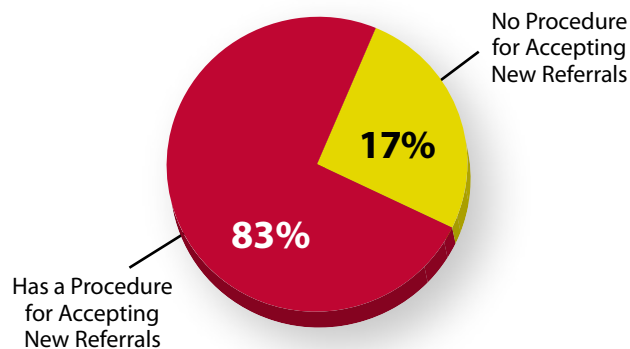
Figure 3.
Child and Youth Mental Health Practitioner Responses:
Does your program/office receive new referrals from Hospital Emergency?



Q11) [Child and Youth Mental Health Practitioner Survey]**Does your program/office have a procedure for accepting new referrals from Hospital Emergency?**

- Child and youth mental health practitioners who could respond to this question (n = 241)
- Approximately 83% of child and youth mental health practitioners indicated that their program/office has a procedure for accepting new referrals from Hospital Emergency
- On the other hand, about 17% of child and youth mental health practitioners reported that their program/office does not have a procedure for accepting new referrals from Hospital Emergency

Figure 4:
Child and Youth Mental Health Practitioner Responses:
Does your program/office have a procedure for accepting new referrals from Hospital Emergency?

**Q12) [Child and Youth Mental Health Practitioner Survey]****When a youth (ages 16 to 18) that my program/office serves visits Hospital Emergency because of a mental health problem, how often do Emergency staff...**

- Inform my program/office of the youths' visit to Emergency**
- Advise my program/office of the youths' mental health condition as assessed during their visit to Emergency**
- Inform my program/office of the outcome of the visit to Emergency (e.g. youth will be returning home, referred to services, admitted to a hospital ward)**
 - On average, child and youth mental health practitioners indicated that Emergency staff communicates the following to their program/office about half the time:
 - Youth's visit to Emergency
 - Youth's mental health condition as assessed during their visit to Emergency
 - Outcome of the visit to Emergency
 - The number of child and youth mental health practitioners who could respond to this question and the distribution of their responses are as follows:
 - *Youth's visit to Emergency* (n = 272; 35% of child and youth mental health practitioners indicated usually or always, and 65% indicated never, seldom or about half the time)
 - *Youth's mental health condition as assessed during their visit to Emergency* (n = 271; 34% of child and youth mental health practitioners indicated usually or always, and 66% indicated never, seldom or about half the time)
 - *Outcome of the visit to Emergency* (n = 272; 30% of child and youth mental health practitioners indicated usually or always, and 70% indicated never, seldom or about half the time)

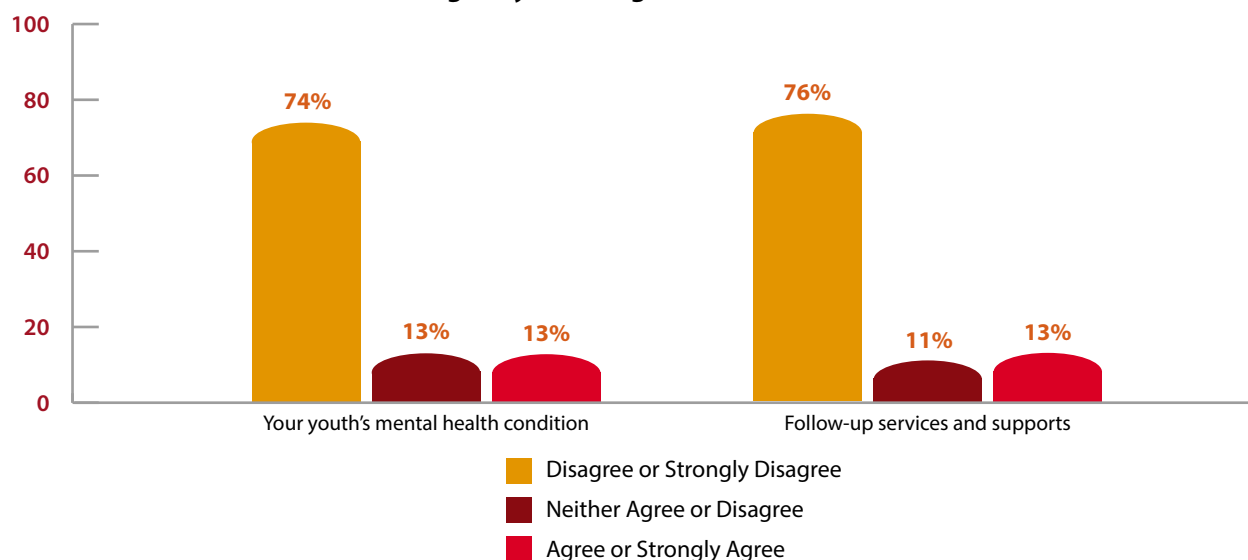
Q13) [Parent and Caregiver Survey]

Before my youth left Emergency, emergency staff gave me enough information on...

a. My youth's mental health condition

b. Follow-up services and supports

Figure 5.
Parent and Caregiver Responses:
Do you agree or disagree that emergency staff gave you enough information on...



- Parents/caregivers who could respond to this question (n = 38)
- On average, parents/caregivers disagreed that they received enough information on their youth's mental health condition and on follow-up services and supports
- Responses are distributed as follows:
 - *Youth's mental health condition* (74% of parents/caregivers disagreed or strongly disagreed; 13% neither agreed nor disagreed; 13% agreed or strongly agreed)
 - *Follow-up services and supports* (76% of parents/caregivers disagreed or strongly disagreed; 11% neither agreed nor disagreed; 13% agreed or strongly agreed)

II. Information Sharing with Physicians Inadequate

Q14) [Physician Survey]

When you refer youth (ages 16 to 18) to community-based child and youth mental health services, how often do child and youth mental health staff...

- a. Advise you of the results of youths' mental health assessments by the child and youth mental health clinician**
- b. Provide you with updates on youths' current mental health statuses and treatment plans**
- c. Advise you when youth are no longer receiving community-based child and youth mental health services**
 - On average, physicians reported that child and youth mental health staff advise them of the results of youths' mental health assessments by the child and youth mental health clinician about half the time
 - Physicians also reported that on average, child and youth mental health staff seldom provide them with updates on youths' current mental health statuses and treatment plans, or advise them when youth are no longer receiving community-based child and youth mental health services
 - The number of physicians who could respond to this question and the distribution of their responses are as follows:
 - *Advise you of the results of youths' mental health assessments by the child and youth mental health clinician* (n = 74; 31% of physicians indicated usually or always, and 69% indicated never, seldom or about half the time)
 - *Provide you with updates on youths' current mental health statuses and treatment plans* (n = 74; 14% of physicians indicated usually or always, and 86% indicated never, seldom or about half the time)
 - *Advise you when youth are no longer receiving community-based child and youth mental health services* (n = 72; 21% of physicians indicated usually or always, and 79% indicated never, seldom or about half the time)

III. Planning Inadequate for Youth Leaving Hospitals and Residential Facilities

Q15) [Child and Youth Mental Health Practitioner Survey]

How often does transition planning take place before a youth (ages 16 to 18) moves from an inpatient/residential treatment facility to outpatient/community mental health services?

- Child and youth mental health practitioners who could respond to this question (n = 277)
- On average, child and youth mental health practitioners reported that transition planning before a youth (ages 16 to 18) moves from an inpatient/residential treatment facility to outpatient/community mental health services usually takes place
- Responses are distributed as follows: 75% of child and youth mental health practitioners indicated usually or always, and 25% indicated never, seldom or about half the time

Q16) [Child and Youth Mental Health Practitioner Survey]

When transition planning occurs for a youth's move from an inpatient/residential treatment facility to outpatient/community mental health services, how often does transition planning take into account the ability of outpatient/community service providers to deliver the planned service?

- Child and youth mental health practitioners who could respond to this question (n = 266)
- On average, child and youth mental health practitioners reported that transition planning takes into account the ability of outpatient/community service providers to deliver the planned service about half the time
- Responses are distributed as follows: 50% of child and youth mental health practitioners indicated usually or always, and 50% indicated never, seldom, or about half the time

Q17) [Child and Youth Mental Health Practitioner Survey]

When a youth (ages 16 to 18) moves from an inpatient/residential treatment facility to outpatient/community mental health services, how often do the following occur?

a. Someone follows the youth until the transition is complete to monitor the status of the youth's mental health condition during the transition period

b. There is a break in service (e.g. due to waitlists, lack of services available, service coordination takes time, etc.)

- On average, child and youth mental health practitioners indicated that the following occurs about half the time:
 - Someone follows the youth until the transition is complete to monitor the status of the youth's mental health condition during the transition period
 - There is a break in service
- The number of child and youth mental health practitioners who could respond to this question and the distribution of their responses are as follows:
 - *Someone follows the youth until the transition is complete to monitor the status of the youth's mental health condition during the transition period* (n = 253; 46% of child and youth mental health practitioners indicated usually or always, and 54% indicated never, seldom, or about half the time)
 - *There is a break in service* (n = 259; 32% of child and youth mental health practitioners indicated usually or always, and 68% indicated never, seldom, or about half the time)

Q18) [Community Social Service Practitioner Survey]

When youth (ages 16 to 18) you are working with leave an inpatient/residential treatment facility, how often does the following occur?

- a. There is there a break in mental health service (e.g. due to waitlists, lack of services available, service coordination takes time, etc.)**
- b. Youth receive ongoing mental health services**
- c. Someone continues to monitor and adjust the youths' medications as applicable**
 - On average, community social service practitioners indicated that a break in mental health service usually occurs
 - Community social service practitioners also indicated that on average, youth receive ongoing mental health services, or someone continues to monitor and adjust the youths' medications as applicable about half the time
 - The number of community social service practitioners who could respond to this question and the distribution of their responses are as follows:
 - *There is a break in mental health service* (n = 59; 66% of community social service practitioners indicated usually or always, and 34% indicated never, seldom, or about half the time)
 - *Youth receive ongoing mental health services* (n = 58; 19% of community social service practitioners indicated usually or always, and 81% indicated never, seldom, or about half the time)
 - *Someone continues to monitor and adjust the youths' medications as applicable* (n = 52; 33% of community social service practitioners indicated usually or always, and 67% indicated never, seldom, or about half the time)

YFPS Services

1) [Child and Youth Mental Health Practitioner Survey]

When a youth has been receiving child and youth mental health services and stops receiving them because they begin court-ordered Youth Forensic Psychiatric Services (YFPS), how often does the following occur?

- a. YFPS receives information about the child and youth mental health services that were provided to the youth**
- b. The child and youth mental health service providers and YFPS discuss how to support the youth's transition to YFPS**
 - On average, child and youth mental health practitioners indicated YFPS usually receives information about the child and youth mental health services that were provided to the youth
 - Child and youth mental health practitioners also indicated that on average, child and youth mental health service providers and YFPS discuss how to support the youth's transition to YFPS about half the time
 - The number of child and youth mental health practitioners who could respond to this question and the distribution of their responses are as follows:
 - *YFPS receives information about the child and youth mental health services that were provided to the youth* (n = 160; 66% of child and youth mental health practitioners indicated usually or always, and 34% indicated never, seldom or about half the time)
 - *The child and youth mental health service providers and YFPS discuss how to support the youth's transition to YFPS* (n = 164; 43% of child and youth mental health practitioners indicated usually or always, and 57% indicated never, seldom or about half the time)

continued on following page

YFPS Services, continued**2) [Child and Youth Mental Health Practitioner Survey]**

When a youth stops receiving court-ordered Youth Forensic Psychiatric Services (YFPS) and is referred to child and youth mental health services for continuing support, how often do the following occur?

- a. The youth experiences a gap in service before the new child and youth mental health service begins**
- b. The new child and youth mental health service provider receives information about the service provided by YFPS**
- c. The new child and youth mental health service provider and YFPS discuss how to support the youth's transition to the new service**
 - On average, child and youth mental health practitioners indicated that the following occurs about half the time:
 - The youth experiences a gap in service before the new child and youth mental health service begins
 - The new child and youth mental health service provider receives information about the service provided by YFPS
 - The new child and youth mental health service provider and YFPS discuss how to support the youth's transition to the new service
 - The number of child and youth mental health practitioners who could respond to this question and the distribution of their responses are as follows:
 - *The youth experiences a gap in service before the new child and youth mental health service begins* (n = 153; 44% of child and youth mental health practitioners indicated usually or always, and 56% indicated never, seldom or about half the time)
 - *The new child and youth mental health service provider receives information about the service provided by YFPS* (n = 159; 49% of child and youth mental health practitioners indicated usually or always, and 51% indicated never, seldom or about half the time)
 - *The new child and youth mental health service provider and YFPS discuss how to support the youth's transition to the new service* (n = 157; 42% of child and youth mental health practitioners indicated usually or always, and 58% indicated never, seldom or about half the time)

Finding:

Existing services do not provide adequate capacity or clear mandates for addressing the mental health needs of transition-age youth.

I. Acute Care Services Not Designed for Transition-age Youth**Services for Youth with Concurrent Mental Health and Substance Use Problems****1. Does Youth Concurrent Mental Health and Substance Use Treatment exist in the Health Service Delivery Area (HSDA)?****Table 4. Youth Concurrent Mental Health and Substance Use Treatment across B.C.**

Health Authority	Health Service Delivery Area	Youth Concurrent Mental Health and Substance Use Treatment Exists	Age Group Served
Vancouver Coastal	Richmond	Yes	16- to 18-year-olds
	Vancouver	Yes	
	North Shore/Coast Garibaldi	Yes	
Fraser	Fraser East	Yes	16- to 18-year-olds
	Fraser North	Yes	
	Fraser South	Yes	
Interior	East Kootenay	Yes	16- to 18-year-olds
	Kootenay Boundary	Yes	
	Okanagan	Yes	
	Thompson Cariboo Shuswap	Yes	
Northern	Northwest	Yes	16- to 18-year-olds
	Northern Interior	Yes	
	Northeast	Yes	
Vancouver Island	South Vancouver Island	Yes	16- to 18-year-olds
	Central Vancouver Island	Yes	
	North Vancouver Island	Yes	

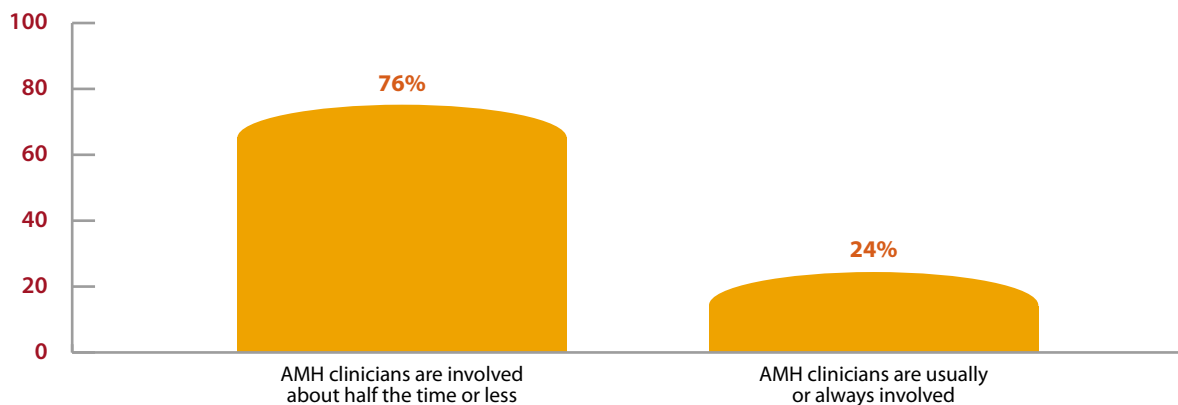
- Health regional contacts report that Youth Concurrent Mental Health and Substance Use Treatment exist in all HSDAs across B.C.

II. Youth Not Well Supported in Transition to Adult Services

Q19) [AMH Clinician Survey]

When youth are transitioning from child and youth mental health services to adult mental health services, how often are AMH clinicians involved in planning for adult services before this transition occurs?

Figure 6.
AMH Clinician Responses:
*How often are AMH Clinicians involved
 in planning for adult services?*



- AMH clinicians who could respond to this question (n = 75)
- On average, AMH clinicians reported that they are seldom involved in planning for adult services before a youth transitions from child and youth mental health services to adult mental health services
- Responses are distributed as follows: 76% of AMH clinicians indicated never, seldom, or about half the time, and 24% indicated usually or always

Q20) [AMH Clinician Survey]

Before a youth transitions from child and youth mental health services to adult mental health services, how often do you receive the following information from the referring child and youth mental health clinician?

a. Youth's mental health history**b. Services and supports that the youth is receiving (e.g. therapy, medication, support group)**

- On average, AMH clinicians indicated that they receive information on the youth's mental health history, or on services and supports that the youth is receiving (e.g. therapy, medication, support group) from the referring child and youth mental health clinician about half the time
- The number of AMH clinicians who could respond to this question and the distribution of their responses are as follows:
 - *Youth's mental health history* (n = 76; 50% of AMH clinicians indicated usually or always, and 50% indicated never, seldom, or about half the time)
 - *Services and supports that the youth is receiving* (n = 77; 51% of AMH clinicians indicated usually or always, and 49% indicated never, seldom, or about half the time)

Q21) [AMH Clinician Survey]

Before a youth transitions from child and youth mental health services to adult mental health services, how often does planning for all services that youth with mental health problems will require after they turn 19 take into account...

a. Housing**b. Vocational support****c. Education****d. Financial support****e. Social support (e.g. positive relationships with others)**

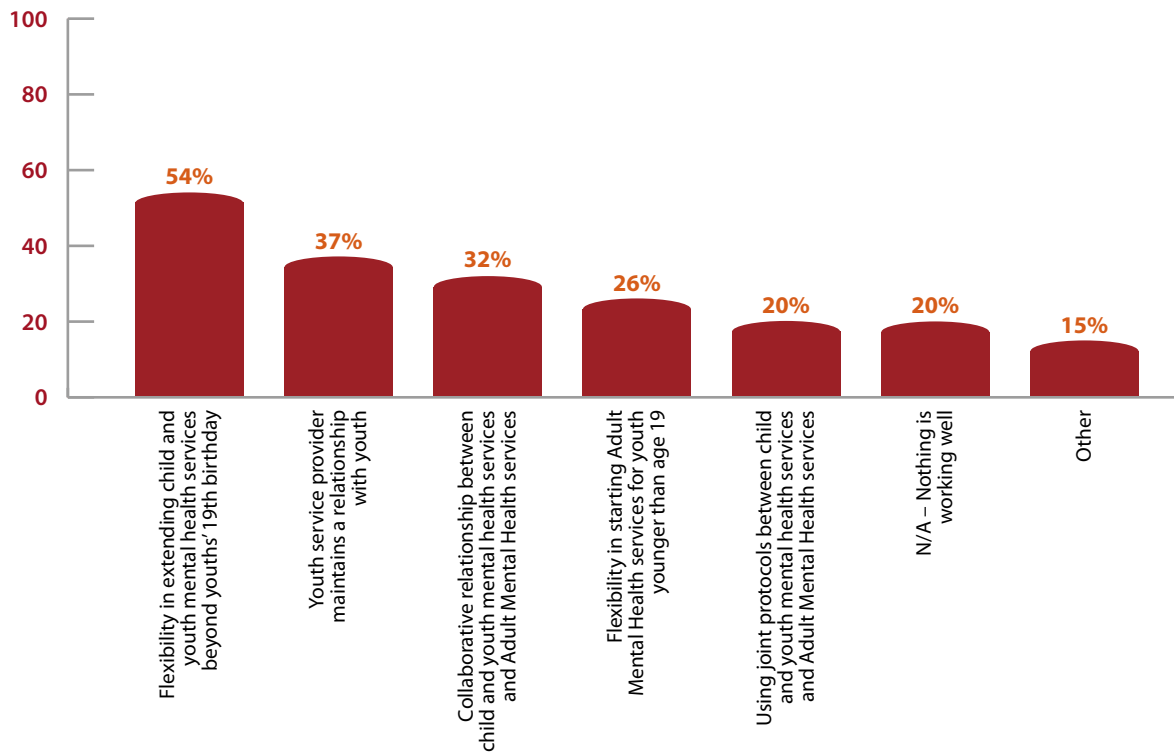
- On average, AMH clinicians indicated that planning for all services takes into account housing, vocational support, education, financial support, or social support about half the time
- The number of AMH clinicians who could respond to this question and the distribution of their responses are as follows:
 - *Housing* (n = 55; 55% of AMH clinicians indicated usually or always, and 45% indicated never, seldom, or about half the time)
 - *Vocational support* (n = 55; 33% of AMH clinicians indicated usually or always, and 67% indicated never, seldom, or about half the time)
 - *Education* (n = 57; 32% of AMH clinicians indicated usually or always, and 68% indicated never, seldom, or about half the time)
 - *Financial support* (n = 58; 52% of AMH clinicians indicated usually or always, and 48% indicated never, seldom, or about half the time)
 - *Social support* (n = 59; 54% of AMH clinicians indicated usually or always, and 46% indicated never, seldom, or about half the time)

Q22) [Child and Youth Mental Health Practitioner Survey]

In your experience, what is currently working well to support youths' transitions to Adult Mental Health services (delivered by a health authority)? Mark all that apply.

- **Not applicable – Nothing is working well to support youths' transitions to Adult Mental Health services (delivered by a health authority)**
- **Collaborative relationship between child and youth mental health services and Adult Mental Health services (delivered by a health authority)**
- **Flexibility in extending child and youth mental health services to youth beyond their 19th birthday**
- **Flexibility in starting Adult Mental Health services (delivered by a health authority) for youth who are younger than age 19**
- **Using joint protocols between child and youth mental health services and Adult Mental Health services (delivered by a health authority) to guide the transition process**
- **A youth service provider maintains a relationship with the youth during a transition period after the youth has begun Adult Mental Health services (delivered by a health authority)**
- **Other (specify)**

**Figure 7.
Child and Youth Mental Health Practitioner Responses:
What is working well to support a youth's transition
to Adult Mental Health services?**



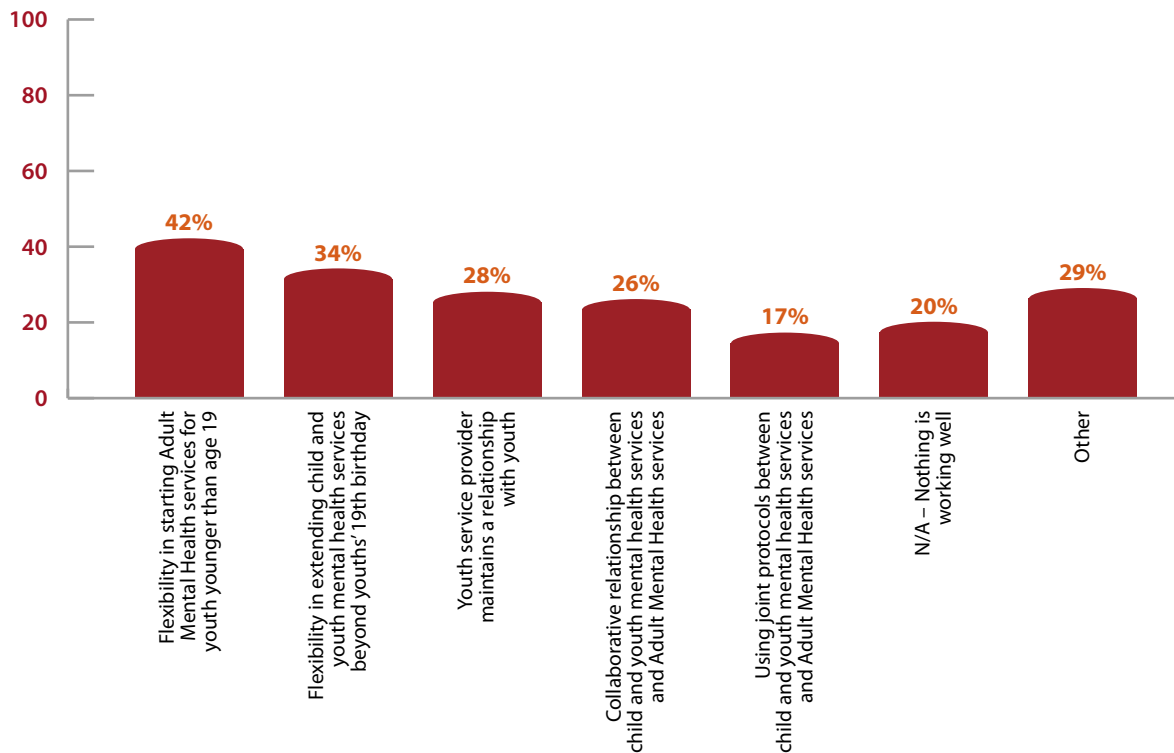
- Child and youth mental health practitioners who could respond to this question (n = 262)
- Responses are distributed as follows:
 - 54% of child and youth mental health practitioners selected flexibility in extending child and youth mental health services to youth beyond their 19th birthday
 - 37% of child and youth mental health practitioners selected a youth service provider maintains a relationship with the youth during a transition period after the youth has begun Adult Mental Health services
 - 32% of child and youth mental health practitioners selected collaborative relationship between child and youth mental health services and Adult Mental Health services
 - 26% of child and youth mental health practitioners selected flexibility in starting Adult Mental Health services for youth who are younger than age 19
 - 20% of child and youth mental health practitioners selected using joint protocols between child and youth mental health services and Adult Mental Health services to guide the transition process
 - 15% of child and youth mental health practitioners specified other aspects including collaborative working relationships, having someone to support and advocate for youth, having a transition protocol/person (e.g. youth transitions committee/consultation), community non-profit supports, and flexibility in how adult services are delivered (e.g. eligibility for service)
- In contrast, 20% of child and youth mental health practitioners indicated that nothing is working well to support youths' transitions to Adult Mental Health services

Q23) [AMH Clinician Survey]

In your experience, what is currently working well to support youths' transitions from child and youth mental health services to Adult Mental Health services? Mark all that apply.

- **Not applicable – Nothing is working well to support a youth's transition to Adult Mental Health services**
- **Collaborative relationship between child and youth mental health services and Adult Mental Health services**
- **Flexibility in extending child and youth mental health services to youth beyond their 19th birthday**
- **Flexibility in starting Adult Mental Health services for youth who are younger than age 19**
- **Using joint protocols between child and youth mental health services and Adult Mental Health services to guide the transition process**
- **A youth service provider maintains a relationship with the youth during a transition period after the youth has begun Adult Mental Health services**
- **Other (specify)**

**Figure 8:
AMH Clinician Responses:
What is working well to support a youth's transition
to Adult Mental Health services?**

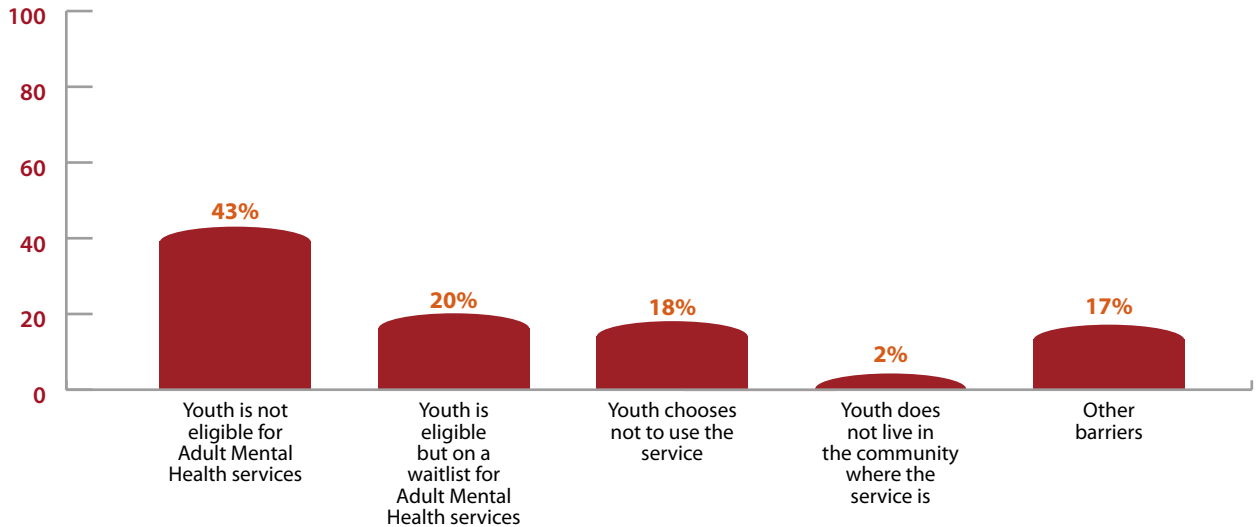


- AMH clinicians who could respond to this question (n = 82)
- Responses are distributed as follows:
 - 42% of AMH clinicians selected flexibility in starting Adult Mental Health services for youth who are younger than age 19
 - 34% of AMH clinicians selected flexibility in extending child and youth mental health services to youth beyond their 19th birthday
 - 28% of AMH clinicians selected a youth service provider maintains a relationship with the youth during a transition period after the youth has begun Adult Mental Health services
 - 26% of AMH clinicians selected collaborative relationship between child and youth mental health services and Adult Mental Health services
 - 17% of AMH clinicians selected using joint protocols between child and youth mental health services and Adult Mental Health services to guide the transition process
 - 29% of AMH clinicians indicated other aspects including collaborative working relationships. Other clinicians also specified aspects that are currently not working well including poor and inconsistent transitioning (e.g. information sent about 6 months prior to their [youth's] 19th birthday; transitions very seldom occur), and limited flexibility for child and youth mental health services to see youth beyond age 19.
- In contrast, 20% of Adult Mental Health clinicians indicated that nothing is working well to support youths' transitions to Adult Mental Health services

Q24) [Child and Youth Mental Health Practitioner Survey]

What is the most common barrier to youth receiving Adult Mental Health services (delivered by a health authority) when they turn 19?

Figure 9.
Child and Youth Mental Health Practitioner Responses:
What is the most common barrier to youth receiving Adult Mental Health services?

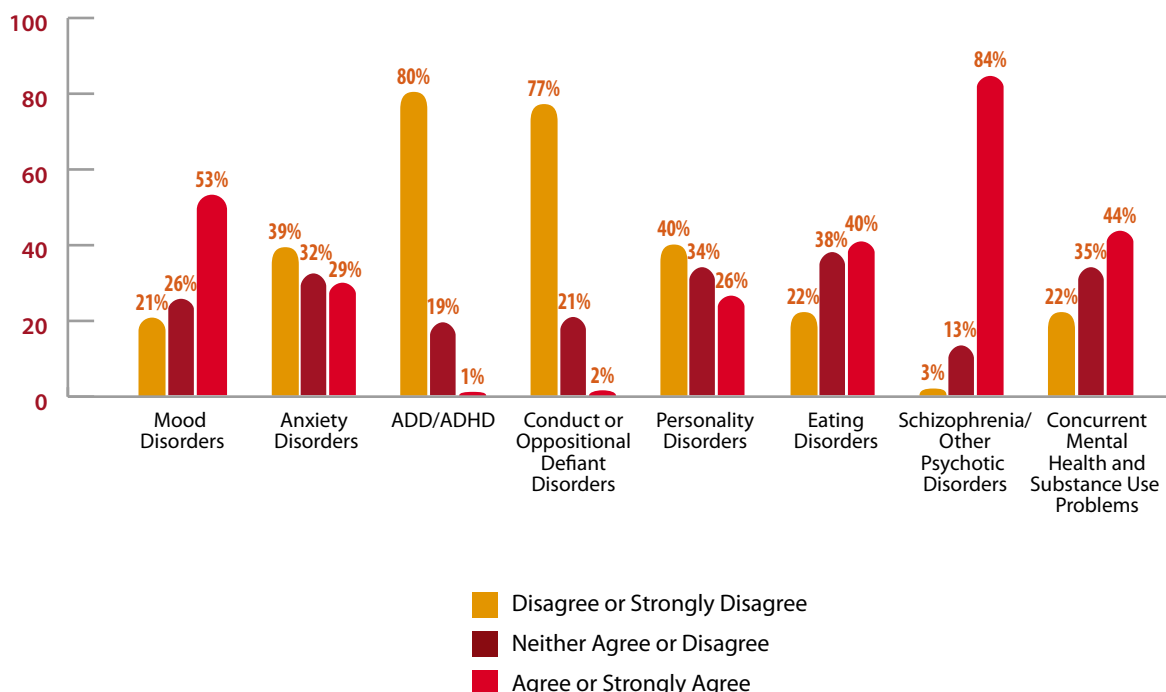


- Child and youth mental health practitioners who could respond to this question (n = 262)
- About 43% of child and youth mental health practitioners indicated that the most common barrier is that the youth is not eligible for Adult Mental Health services
- 17% of child and youth mental health practitioners specified other barriers including:
 - Adult services do not support youth in the same 'held way' provided by CYMH
 - Minimal outreach or engagement with youth to attend an adult service
 - Service is not user friendly for youth
 - Lack of communication between child and youth mental health and Adult Mental Health

Q25) [Child and Youth Mental Health Practitioner Survey]

Youth with the following primary disorders usually receive Adult Mental Health services (delivered by a health authority) after they turn 19:

Figure 10.
Child and Youth Mental Health Practitioner Responses:
Do you agree or disagree that youth with the following primary disorders usually receive Adult Mental Health services?



- Child and youth mental health practitioners who could respond to this question (n = 262)
- On average, child and youth mental health practitioners disagreed that youth with the primary disorders of Attention-Deficit/Hyperactivity Disorders or Conduct or Oppositional Defiant Disorders usually receive Adult Mental Health services (delivered by a health authority) after they turn 19
- Responses are distributed as follows:
 - *Attention-Deficit/Hyperactivity Disorders* (80% of child and youth mental health practitioners disagreed or strongly disagreed; 19% neither agreed nor disagreed; 1% agreed or strongly agreed)
 - *Conduct or Oppositional Defiant Disorders* (77% of child and youth mental health practitioners disagreed or strongly disagreed; 21% neither agreed nor disagreed; 2% agreed or strongly agreed)

Q26) [AMH Clinician Survey]**Are youth diagnosed with the following disorders typically eligible for Adult Mental Health services?**

- The number of AMH clinicians who could respond to this question and the distribution of their responses are presented below
- According to AMH clinicians, youth with the following disorders are typically eligible for Adult Mental Health services:
 - *Schizophrenia or Other Psychotic Disorders* (n = 78; 92% of AMH clinicians indicated “yes”)
 - *Mood Disorders* (n = 78; 87% of AMH clinicians indicated “yes”)
 - *Concurrent Mental Health and Substance Use Problems* (n = 80; 86% of AMH clinicians indicated “yes”)
 - *Anxiety Disorders* (n = 77; 81% of AMH clinicians indicated “yes”)
 - *Eating Disorders* (n = 72; 74% of AMH clinicians indicated “yes”)
 - *Personality Disorders* (n = 75; 65% of AMH clinicians indicated “yes”)
- In contrast, youth with the following disorders are typically not eligible for Adult Mental Health services:
 - *Attention-Deficit/Hyperactivity Disorders* (n = 68; 56% of AMH clinicians indicated “no”)
 - *Behavioural Disorders - e.g. Conduct Disorder, Oppositional Defiant Disorder* (n = 67; 66% of AMH clinicians indicated “no”)

Q27) [Child and Youth Mental Health Practitioner Survey]**For youth (ages 16 to 18) who are receiving child and youth mental health services, how often does planning occur for mental health services they require after they turn 19?**

- Child and youth mental health practitioners who could respond to this question (n = 241)
- On average, child and youth mental health practitioners reported that planning for mental health services that youth (ages 16 to 18) will require after they turn 19 usually occurs
- Responses are distributed as follows: 63% of child and youth mental health practitioners indicated usually or always, and 37% indicated never, seldom or about half the time

Q28) [Parent and Caregiver Survey]**Has there been any planning for services your youth will receive after turning 19?**

- Parents/caregivers who could respond to this question (n = 87)
- Most parents/caregivers (or 92%) reported that there has not been any planning for services that their youth would receive after turning 19. Only 8% of parents/caregivers reported that there has been planning for services that their youth would receive after turning 19

Q29) [Community Social Service Practitioner Survey]

For youth (ages 16 to 18) who are receiving child and youth mental health services, how often does planning occur for mental health services that these youth will require after they turn 19

- Community social service practitioners who could respond to this question (n = 73)
- For youth who are receiving child and youth mental health services:
 - On average, community social service practitioners indicated that planning for mental health services that these youth will require after they turn 19 occurs about half the time
 - Responses are distributed as follows: 26% of community social service practitioners indicated usually or always, and 74% indicated never, seldom or about half the time

Q30) [Community Social Service Practitioner Survey]

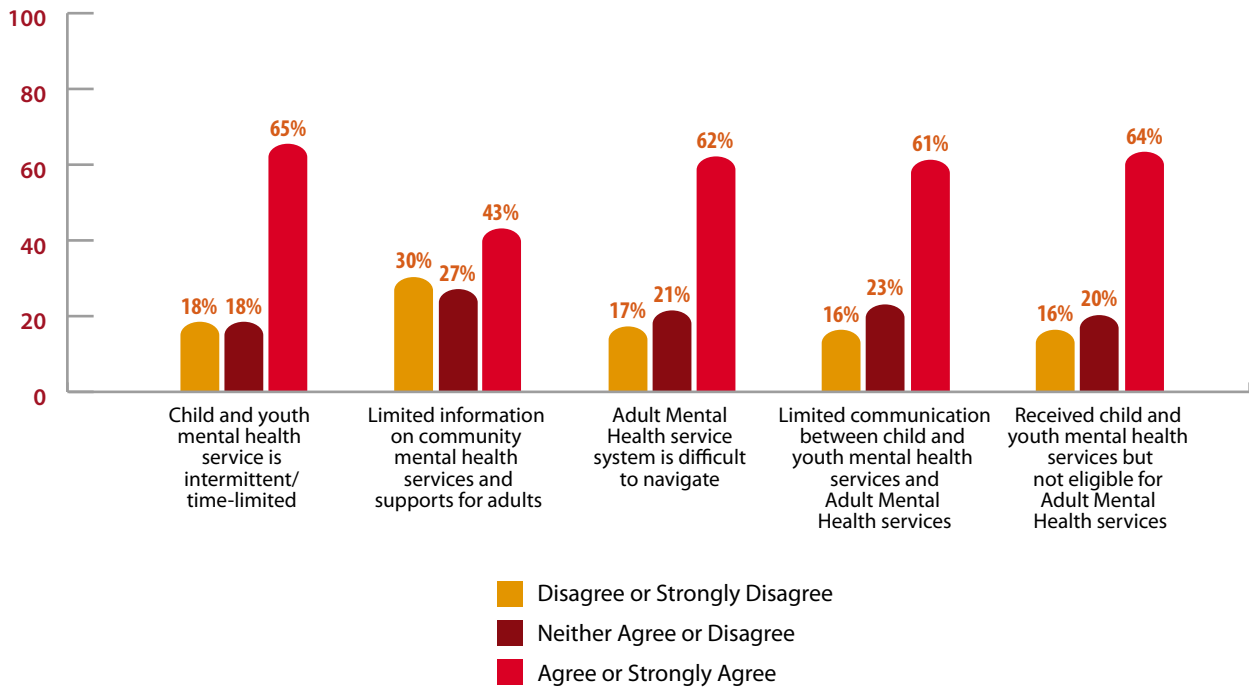
For youth (ages 16 to 18) who are not receiving child and youth mental health services, how often does planning occur for mental health services that these youth will require after they turn 19?

- Community social service practitioners who could respond to this question (n = 69)
- For youth who are not receiving child and youth mental health services:
 - On average, community social service practitioners indicated that planning for mental health services that these youth will require after they turn 19 seldom occurs
 - Responses are distributed as follows: 4% of community social service practitioners indicated usually or always, and 96% indicated never, seldom or about half the time

Q31) [Child and Youth Mental Health Practitioner Survey]

It is difficult to plan ahead for services that youth with mental health problems will require after turning 19 because...

Figure 11.
Child and Youth Mental Health Practitioner Responses:
Do you agree or disagree that the following reasons make it difficult to plan ahead for services that youth with mental health problems will require after turning 19?



- Child and youth mental health practitioners who could respond to this question (n = 262)
- On average, child and youth mental health practitioners agreed that it is difficult to plan ahead for services that youth with mental health problems will require after turning 19 because child and youth mental health service is intermittent and time-limited
- Responses are distributed as follows: 65% of child and youth mental health practitioners agreed or strongly agreed; 18% neither agreed nor disagreed; 18% disagreed or strongly disagreed

Q32) [Child and Youth Mental Health Practitioner Survey – MCFD-Funded Child and Youth Mental Health Practitioners Only]

NOTE: This question is unique to MCFD-funded Child and Youth Mental Health Practitioners, and analyses for this question only reflect the responses of these practitioners

For youth who will require mental health services after they turn 19, how often is a child and youth mental health service provider involved in planning for these services when the youth:

a. Has an open file and is not currently receiving child and youth mental health service

- MCFD-funded child and youth mental health practitioners who responded to this question (n = 212)
- Approximately 30% of MCFD-funded child and youth mental health practitioners (n = 63) reported that they “don’t know” how often a child and youth mental health service provider is involved in planning for these youth
- Of those MCFD-funded child and youth mental health practitioners who could respond to this question (n = 149 when “don’t know” responses are omitted):
 - On average, MCFD-funded child and youth mental health practitioners indicated that a child and youth mental health service provider is involved in planning for these services about half the time
 - Responses are distributed as follows: 36% of MCFD-funded child and youth mental health practitioners indicated usually or always, and 64% indicated never, seldom or about half the time

b. Is a former client of the child and youth mental health service provider and has a closed file

- MCFD-funded child and youth mental health practitioners who responded to this question (n = 212)
- Approximately 24% of MCFD-funded child and youth mental health practitioners (n = 50) reported that they “don’t know” how often a child and youth mental health service provider is involved in planning for these youth
- Of those MCFD-funded child and youth mental health practitioners who could respond to this question (n = 162 when “don’t know” responses are omitted):
 - On average, MCFD-funded child and youth mental health practitioners indicated that a child and youth mental health service provider is seldom involved in planning for these services
 - Responses are distributed as follows: 4% of MCFD-funded child and youth mental health practitioners indicated usually or always, and 96% indicated never, seldom or about half the time

Q33) [Child and Youth Mental Health Practitioner Survey]

When planning occurs for mental health services that youth (ages 16 to 18) will require after they turn 19, how often are the following people involved?

- a. Youth**
- b. Child and Youth Mental Health Clinician**
- c. Youth's Parent/Caregiver**
- d. Adult Mental Health Clinician**
- e. Psychiatrist**
- f. Non-Clinical Support Worker**
- g. Family Doctor/Pediatrician**
- h. School Staff**

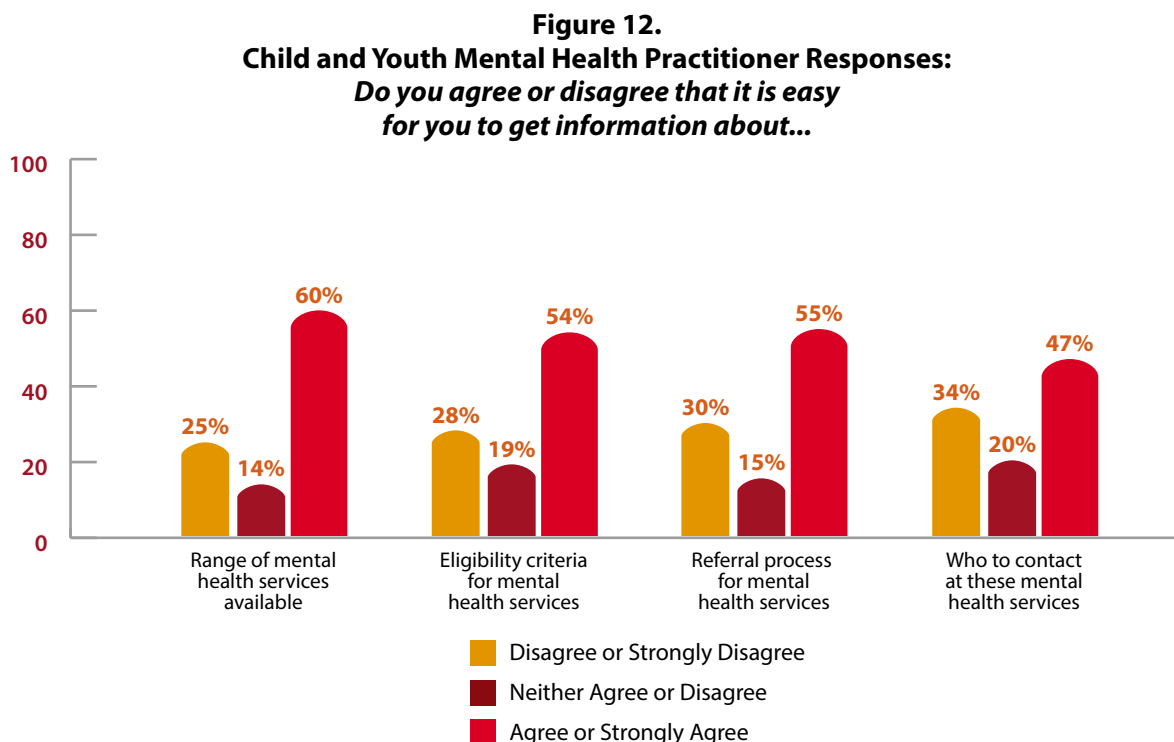
- On average, child and youth mental health practitioners indicated that family doctors/pediatricians are involved in planning for mental health services for youth after age 19 about half the time
- The number of child and youth mental health practitioners who could respond to this question and the distribution of their responses are as follows:
 - *Youth* (n = 235; 89% of child and youth mental health practitioners indicated usually or always, and 11% indicated never, seldom, or about half the time)
 - *Child and Youth Mental Health Clinician* (n = 237; 86% of child and youth mental health practitioners indicated usually or always, and 14% indicated never, seldom, or about half the time)
 - *Youth's parent/caregiver* (n = 230; 70% of child and youth mental health practitioners indicated usually or always, and 30% indicated never, seldom, or about half the time)
 - *AMH clinician* (n = 219; 53% of child and youth mental health practitioners indicated usually or always, and 47% indicated never, seldom, or about half the time)
 - *Psychiatrist* (n = 221; 42% of child and youth mental health practitioners indicated usually or always, and 58% indicated never, seldom, or about half the time)
 - *Non-clinical support worker* (n = 219; 33% of child and youth mental health practitioners indicated usually or always, and 67% indicated never, seldom, or about half the time)
 - *Family doctor/pediatrician* (n = 213; 28% of child and youth mental health practitioners indicated usually or always, and 72% indicated never, seldom, or about half the time)
 - *School staff* (n = 213; 12% of child and youth mental health practitioners indicated usually or always, and 88% indicated never, seldom, or about half the time)

Finding:

There is a failure of provincial leadership and quality assurance for mental health services for youth.

Q34) [Child and Youth Mental Health Practitioner Survey]

Please indicate how strongly you agree or disagree with the following. It is easy for me to get information about...



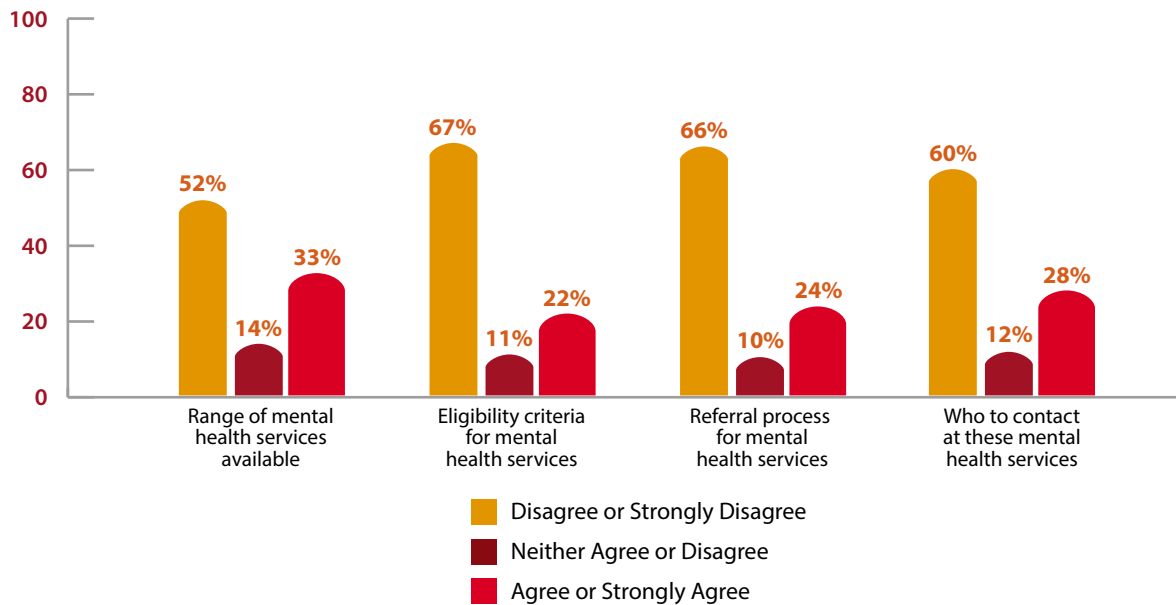
- Child and youth mental health practitioners who could respond to this question (n = 338)
- On average, child and youth mental health practitioners indicated that they neither agreed nor disagreed that it is easy for them to get information about the following:
 - The range of mental health services available to youth ages 16 to 18
 - Eligibility criteria for each of the mental health services available to youth ages 16 to 18
 - The referral process for each of these mental health services, including self-referral
 - Who to contact at these mental health services
- Responses are distributed as follows:
 - *The range of mental health services available to youth ages 16 to 18* (60% of child and youth mental health practitioners agreed or strongly agreed; 14% neither agreed nor disagreed; 25% disagreed or strongly disagreed)
 - *Eligibility criteria for each of the mental health services available to youth ages 16 to 18* (54% of child and youth mental health practitioners agreed or strongly agreed; 19% neither agreed nor disagreed; 28% disagreed or strongly disagreed)

- The referral process for each of these mental health services, including self-referral (55% of child and youth mental health practitioners agreed or strongly agreed; 15% neither agreed nor disagreed; 30% disagreed or strongly disagreed)
- Who to contact at these mental health services (47% of child and youth mental health practitioners agreed or strongly agreed; 20% neither agreed nor disagreed; 34% disagreed or strongly disagreed)

Q35) [Community Social Service Practitioner Survey]

Please indicate how strongly you agree or disagree with the following. It is easy for me to get information about...

Figure 13.
Community Social Service Practitioner Responses:
Do you agree or disagree that it is easy for you to get information on...



- Community social service practitioners who could respond to this question (n = 90)
- On average, community social service practitioners indicated that they neither agreed nor disagreed that it is easy for them to get information about the range of mental health services available to youth ages 16 to 18, or who to contact at these mental health services
- Community social service practitioners also indicated that on average, they disagreed that it is easy for them to get information about eligibility criteria for each of the mental health services available to youth ages 16 to 18, or the referral process for each of these mental health services, including self-referral

- Responses are distributed as follows:
 - *The range of mental health services available to youth ages 16 to 18* (52% of community social service practitioners disagreed or strongly disagreed; 14% neither agreed nor disagreed; 33% agreed or strongly agreed)
 - *Eligibility criteria for each of the mental health services available to youth ages 16 to 18* (67% of community social service practitioners disagreed or strongly disagreed; 11% neither agreed nor disagreed; 22% agreed or strongly agreed)
 - *The referral process for each of these mental health services, including self-referral* (66% of community social service practitioners disagreed or strongly disagreed; 10% neither agreed nor disagreed; 24% agreed or strongly agreed)
 - *Who to contact at each of these mental health services to get information about them* (60% of community social service practitioners disagreed or strongly disagreed; 12% neither agreed nor disagreed; 28% agreed or strongly agreed)

Q36) [Physician Survey]

Is it easy for you to get information about the range of mental health services available to youth (ages 16 to 18) in your community?

- Physicians who could respond to this question (n = 85)
- Approximately 68% of physicians indicated that it is not easy for them to get information about the range of mental health services available to youth (ages 16 to 18) in their community. On the other hand, 32% of physicians reported that it is easy

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