

# A Review of Child and Youth Mental Health Services in BC

*following implementation of the 2003  
Child and Youth Mental Health Plan*

Prepared for  
The Ministry of Children and Family  
Development

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## Executive Summary

### *Promises Kept, Miles to Go: A Review of Child and Youth Mental Health Services in BC following implementation of the 2003 Child and Youth Mental Health Plan*

#### KEY POINTS IN THIS REPORT

Overall, stakeholders strongly support the CYMH Plan and feel it provided great vision and a welcome boost in resources, however there is a long journey ahead requiring additional resources and a firm grip.

1. All external stakeholders and MCFD staff were impressed with the Plan: its coherence and follow-through, the commitment to upstream programs and evidence-based practice, the focus on Aboriginal communities and the new resources.
2. Families are somewhat more involved although still much to be done.
3. Although other Ministries share some responsibility, stakeholders and partners expect MCFD executive to maintain the momentum with strong leadership.
4. Services and approaches vary across regions and sub-regions.
5. Effective planning and monitoring require robust regional direction and better data.
6. Engage partners and communities by rebuilding the CYMH Network and embedding family perspectives and resources into all activities.
7. Joint working with schools, Health Authorities and physicians should be a priority, especially for risk reduction and community capacity building.
8. Improve waiting times using evidence-based approaches, process improvement methods and targets.
9. Fund more regional treatment supports (day programs and step-up/down).
10. Strengthen partnerships with universities for training and research.

#### Bottom line:

**This is a cross-government, all-society issue,  
but MCFD leadership is critical.**

## Chapter One – Introduction

This review was commissioned by the Ministry of Children and Family Development [MCFD]. The purpose was to:

- review the Child and Youth Mental Health service system subsequent to implementation of the *Child and Youth Mental Health Plan for British Columbia*,
- identify remaining gaps in programs and services, and
- recommend next steps for continued service system improvement.

Consultations were held with community stakeholders, partners in other Ministries, service providers, families of children and youth with mental illness, and youth clients themselves from May to July 2008.

### BACKGROUND

The BC Government approved the five-year *Child and Youth Mental Health Plan for British Columbia*, [“the Plan”] in February 2003 with an investment of \$44M, approximately doubling the annualized budget for CYMH Services. The Plan focused on four key strategies (which we have used to organize this report):

1. Risk reduction – formal efforts to prevent or delay onset of mental health problems in children and youth, or mitigate the impact of mental health problems;
2. Capacity building – strengthening the positive influence of families and communities to promote and support the mental health of children and youth;
3. Treatment and support – ensuring access to a continuum of timely, evidence-based, effective services to children and youth with mental health problems and their families;
4. Performance improvement – strengthening the infrastructure to support a responsive, efficient and accountable child and youth mental health system.

The Plan recognized both the need **to increase treatment capacity and to emphasize “upstream” strategies** that intervene earlier in the lives of children before problems develop. A key principle throughout the Plan was **the promotion of evidence-based practice** to improve effectiveness in all CYMH services. Further, the Plan sought to address the needs of underserved populations such as Aboriginal children and children from multi-cultural groups.

The new funding was allocated to the five MCFD regions to support implementation of Plan initiatives. The **regional allocation strategy**, based on a socio-economic formula, dedicated funds to risk reduction (15%) and capacity building (15%), supporting the shift toward earlier interventions. \$10.1 M was dedicated to the development of culturally relevant services for Aboriginal children, youth and their families and new investments were guided by regional Aboriginal planning processes.

## REVIEW APPROACH

Sources of information for this review included consultation with MCFD staff; interviews with selected individuals (n=37); focus groups with representatives of the health and education systems, community service providers, parents, youth and MCFD regional teams (n=240); on-line surveys completed by three groups: parents (n=89); CYMH team leaders (n=65); front-line MCFD staff (n=215); and documents such as regional plans, activity reports, educational materials and the “Strong, Safe and Supported” plan. **Over 600 individuals participated directly.** We have made every effort to present a reasonable reflection of various perspectives, while focusing on our deliverables regarding strategic advice about next steps.

Although our recommendations are intended for MCFD staff, we recognize that **one Ministry of government is not solely responsible and cannot possibly address the issues alone.** Effectively tackling the myriad challenges affecting CYMH will require a whole community, cross-government approach with significant public support especially against stigma and discrimination.

## AUTHOR’S PREFACE

**We heard overwhelming support for the Plan from MCFD staff, clinicians, advocates and family members.** We do not want to lose this overall approval in the constructive criticism in this report. At the same time, there is a perception of stalled momentum. Many stakeholders feel that **more time, additional resources and on-going commitment are needed.** One said, “Five years is too short a time. After all the effort to get our boat in the water, we ran out of sea.”

## Chapter Two - Reducing Risk

Risk reduction strategies aim to prevent problems before they occur, delay the development of disorders, or reduce their impact on functioning. Typically, risk reduction activities occur in community settings. Within MCFD, **we heard strong support for the emphasis on preventive work.** From our survey, Team Leaders think early intervention has improved. Respondents from schools and community agencies are also very positive about the Plan's "upstream" focus.

### THE PLAN PROVIDED BETTER INFORMATION ABOUT MENTAL HEALTH PROBLEMS

The people we spoke with feel that **public education has been addressed very well.** Over 80% of Team Leaders think education of families and the public about CYMH is "better" or "much better". Family members in our focus groups referred to materials produced provincially, while community agencies pointed to specialized materials they were supported to produce with Plan funding. **The TV documentaries produced for MCFD by the Knowledge Network were cited as an excellent resource.** Community groups spoke of the importance of communicating in languages other than English. With the diversity of immigrant groups in BC, further work is needed to capture all language groups; also all materials require constant updating. We recommend a coordinated effort to translate materials and a system to facilitate sharing resources.

### FURTHER COORDINATION WOULD HELP TO REDUCE RISK AND INTERVENE EARLY

Many community representatives see a need for better coordination with Ministry of Health Services [MoHS] and Ministry of Healthy Living and Sport [MHLS] to improve preventive services, especially those aimed at **strengthening the early mother-child relationship.** It is critical to involve Physicians in prevention work as they see children in early stages of problems. Several stakeholders said that expanding parenting support programs at all ages, especially home visitation programs for new mothers, should be a priority.

Several people commented on **successful partnerships between MCFD and Ministry of Education [MEd]** -- and that more is needed. Examples abound, including FRIENDS, various parenting programs, "resiliency" programs, outreach support by MCFD-CYMH staff in schools, peer counselling and after-hours services. School district staff favour more "joint ventures" with MCFD, through co-funding and co-management of programs. **FRIENDS a strength-based, resiliency-building program, is widely seen as extremely helpful.** Teachers in our focus groups agreed strongly that MCFD should promote the FRIENDS program vigorously. Family advocates also view it very favourably, only adding that some parents would like FRIENDS offered earlier.

## Chapter Three – Building Community Capacity

Capacity building initiatives foster mental health, support children with mental disorders, educate the public, and decrease stigma associated with mental illness. **The capacity building efforts of the CYMH Plan are widely supported as an excellent approach - progressive, relevant and timely.** Over 75% of the MCFD Team Leaders reported improvements in community capacity to support children and youth with mental health problems. Capacity development is seen as congruent with strength-based services and the five pillars of the Strong, Safe and Supported approach. Community stakeholders stated that **the Plan gave them a sense of renewed hope and faith in the government's commitment** to this issue.

### TRAIN COMMUNITY SERVICE PROVIDERS

We heard of various community-oriented training programs funded by the Plan. These programs increase skills in identifying and referring problems and **should be intensified among key community service providers** such as MCFD staff in program areas outside of CYMH, health and early childhood professionals, schoolteachers and crisis responders such as firefighters and RCMP officers.

### CONTINUE TO BUILD PARTNERSHIPS WITH ORGANIZATIONS ACROSS MANY SECTORS

The Plan identified a need to improve partnerships with MoHS, Health Authorities [HA], MHLS, MEd, school districts, and physicians. Most stakeholders agree. The Plan led to several **inter-ministerial projects including** working on transitions between hospital and community-based services, and from MCFD to the MoHS system; youth concurrent disorders; the Early Psychosis Initiative and training of First Nations schoolteachers. In the field, over 97% of front-line MCFD-CYMH staff who responded to our survey reported that they routinely coordinate service delivery with child welfare, school districts, and public health services. **This outstanding response shows the importance clinicians place on these partnership efforts.** (Unfortunately, parents view this quite differently. We discuss their views below since most refer to treatment and support issues.) **The Child and Youth Mental Health Network** with representatives from MCFD, MoHS, MEd and others has a mandate to coordinate service delivery and resolve issues. However, the Network is seen as lacking a focus. Network members will revise Terms of Reference in fall 2008.

### MCFD AND MINISTRY OF EDUCATION NEED TO WORK MORE CLOSELY

**Partnership work with school districts should be a priority.** We heard from family advocates that schools are often parents' greatest concern. They recommend more access to CYMH services in schools. The parents we spoke with were generally negative about their experiences with the school system. Despite several examples of positive partnership, we mostly heard of inconsistent collaboration between School District and MCFD staff. Many parents reported that

teachers lacked knowledge about CYMH issues. Both parents and providers recommended that **teacher education and professional development programs should inform educators about CYMH issues**, such as early identification, communication with families and how to access resources.

### **MCFD AND MINISTRIES OF HEALTH NEED TO WORK MORE CLOSELY TOGETHER**

Presently work is underway in MoHS and MHLs on a proposed Ten Year Mental Health and Substance Use Plan. The aim is to integrate across all Ministries' plans with a whole system, whole government approach. Several people suggested that **MCFD needs to be included more actively in the Ten Year Plan development**. A specific area for joint working is youth addictions. Many youth present with concurrent disorders, requiring services from both Ministries. Presently this is difficult to arrange; providers said the services are fragmented, subject to turf wars, with few mechanisms to compel collaboration. This topic needs attention from senior staff. **More generally, funding from all three Ministries could incentivize projects that encourage joint working**. Any new funding could be directed to shared projects requiring collaborative planning and evaluation.

### **FULLY INVOLVE FAMILIES AT ALL LEVELS OF PLANNING AND DELIVERY OF SERVICES**

A provincial External Advisory Committee involving families and advocates was created in the early years of the Plan. However, there is currently no formal voice for families at the provincial level. Similarly, in some regions, parents sit on various committees but **there are few venues where family members can provide input to policies and plans**. HA involvement of families in planning of CYMH services is also described as weak by both providers and parents. One stakeholder commented, *"Sometimes, families have to fight to be heard."* We recommend additional support for this important resource.

Regarding service delivery, **family involvement in individual assessment, treatment and evaluation is seen as "hit-and-miss"**. With regard to their ability to be involved in care planning for their child, 41% of parents or guardians responding to our survey were satisfied or very satisfied, 38% were dissatisfied or very dissatisfied, and 21% were uncertain. **Parent resource groups deserve special mention** as one way to help families while they wait to be seen by CYMH clinicians. Presently, parent groups operate in some communities through The FORCE. Parents have a range of capabilities and needs, and often feel disconnected from the service system.



**FIGURE E-2      WHAT YOUTH TOLD US**

*There should be information about mental health everywhere - on planes, in magazines, on the radio - with phone numbers about how to get help.*

*Once you get in things are pretty dandy - once you have finally crawled in and claimed your spot. But getting in is a whole lot more work than it needs to be.*

*Privacy is not my priority. I want my counsellor to share my personal information [with other clinicians who need to know], unless I tell them not to.*

**FIGURE E-3      WHAT PARENTS TOLD US**

*Support in school for kids with CYMH issues seems to depend on each principal.*

*If we didn't get these services my son would not be able to function. It has helped him immensely.*

*GPs and even pediatricians are woefully undereducated in children's mental health issues.*

*I'm just happy I found a support group to help me through things.*

*We are tired and we want someone else to be responsible and tell us what to do, rather than us telling them what we need all the time.*

*Working with whole families needs further emphasis...to bring systems and families together.*

From the on-line survey, the most common concerns of parents were:

- Difficulties accessing appropriate care and long-wait times for service;
- Insufficient support to navigate a complex formal care system and to secure services which were appropriate to the client need;
- Lack of coordination among providers within the system;
- Limited information for families and inadequate communication;
- Transitioning from youth to adult mental health services;
- Limited opportunity for early intervention so that problems progress.

**Co-location of CYMH services with child protection is problematic for parents**, according to both providers and community members. We recommend considering alternative placement of CYMH services away from child protection functions to enhance accessibility. We recognize that this appears inconsistent with other recommendations calling for greater coordination and integration. However, extra hassle for staff can be mitigated with electronic communication and process improvement methods. The perception of families is much harder to shift.

## **SUPPORT ABORIGINAL MENTAL HEALTH**

Despite the issues to be resolved, stakeholders told us that **the strategic focus on Aboriginal mental health is a significant step forward for MCFD**. The most important accomplishment of the Plan in this area was the allocation of funds (\$10.1 million) dedicated for services to Aboriginal children and youth. **Regional Aboriginal Planning Committees developed plans in all regions**. As a result, fifty-six new positions have been dedicated to Aboriginal services. We heard many positive reports about CYMH outreach workers in Aboriginal communities, who provide some assessment and treatment services, help with service connections and meet regularly with local providers and community members to build capacity. This outreach activity needs further development in most regions. We list in the report many other innovative regional initiatives funded by the Plan.

To the question, “Is there consistent and effective involvement of Aboriginal communities in service planning and delivery”, **most respondents in our focus groups said “Involvement, yes, but not consistently.”** Some staff commented that provincial leadership around Aboriginal CYMH is unclear. Overall, there appears to be **a widely shared opinion that there have been significant gains, but much work remains**.

**Cultural views related to service delivery are critical**. A key theme we heard is the issue of balancing Aboriginal views of mental health with appropriate medical supports. Another concern of stakeholders is accepting influence from the community, so as to ensure that services are appropriate and effective. Several Aboriginal CYMH staff commented on the lack of a spiritual component in the education material available. Others noted that building trust is fundamental.

**Community based programs, especially for prevention of CYMH issues, are difficult to evaluate**. MCFD Regional Aboriginal Service Managers requested support in the form of performance indicators, outcome measures and evaluation mechanisms. We share the view that it would be useful to **support research on data capture and evaluation for these activities**.

**FIGURE E-4 NEW STAFF HIRED WITH PLAN FUNDING, BY MCFD REGION 2005-08**

REGION	Clinical Generalist	Clinical Specialist	Support Worker	Aboriginal Programs	Unspecified	REGIONAL TOTAL
FRASER	27.48	38.82	4.86	18	-	89.16
INTERIOR	42.75	16.5	10	7	-	76.25
NORTH	16.25	-	7.5	25	9	57.75
VAN.COASTAL	12.5	14.5	2.5	2	-	31.5
VAN.ISLAND	16.46	3.5	1.5	18.8	-	40.26
<b>PROVINCIAL TOTALS</b>	<b>115.44</b>	<b>73.32</b>	<b>26.36</b>	<b>70.8</b>	<b>9</b>	<b>294.92</b>

## Chapter Four – Improving Treatment and Support

Children and their families need access to a continuum of timely, evidence-based, effective mental health assessment and treatment services. This strategy addresses gaps in the basic range and level of services in each region to improve access and service.

### THE PLAN FUNDED A BASIC LEVEL AND RANGE OF CORE SERVICES IN EVERY REGION

In the survey of Team Leaders, 87% said that **the basic range, and level, of core mental health services in their region was “better” or “much better”**. However it would be helpful to define the basic universal programs available in every region (whether from MCFD, MEd or MoHS) to ensure consistency. Despite high praise for the new staff and resources announced in the Plan (Figure E-4), there were also concerns about lack of information about how the regions implemented the new hires. We recommend sharing widely the information about the new resources as part of a continuing accountability and communication process.

**As expected we also heard from most community stakeholders (HA, agency, school staff and families) about on-going concerns regarding access for children in crisis. They applaud early intervention and value support from “high-end” programs. However, some children deteriorate to the point of needing hospitalization before they access services. We heard**

from all regions that kids who are moderately disturbed may “fall through the cracks” until they reach a critical level.

One of the key issues affecting this problem is **the lack of hospital beds and community residential programs in many communities**. The survey of MCFD Team Leaders reinforced the stakeholder comments with only 8% reporting any improvement in the continuum of residential services; the remainder think the situation is unchanged (58%) or worse (34%).

### A SIGNIFICANT GAP BETWEEN RESOURCES AND NEEDS

Many researchers agree with the estimates in the 2003 Plan that about 15% of children suffer diagnosable mental health concerns. Even with a more conservative estimate, serious functional impairment affects 10%, or more than 97,000 children and youth in BC. Plan resources increased the number of children receiving service by MCFD staff from about eleven thousand per year to about twenty thousand (no firm data available). Although GPs and community counselors also provide services to some youth with mental health problems, **the gap between resources and needs remains large** (Figure E-5).

**FIGURE E-5 PREVALENCE AND SERVICE ESTIMATES**

Year	2003	2008
BC Pop <19	989,192	973,429
Impact at 1 in 7	138,487	136,280
Impact at 1 in 10	98,919	97,343
Served by MCFD	11,000	20,000
% served if 1 in 7	7.9%	14.7%
% served if 1 in 10	11.1%	20.5%
Gap at 1 in 10	87,919	77,343

Regarding **wait times** for service, no objective data or benchmarks are available. Subjectively, **the feedback about wait times was generally negative**: In our survey, 57% of MCFD Team Leaders report that the gap between services and need had improved; the other 43% feel that the gap was unchanged or worse. However, over 90% of the front-line staff think that service capacity is inadequate for the current demand. Providers such as **physicians and residential services managers usually did not report significant improvement in waiting times**. In our focus groups, **almost all parents spoke of very long waits**, often noting that they only received service after their child had deteriorated significantly from first referral. Most of the parents reported problems with access to services (55% dissatisfied); a few found wait times acceptable.

**Summing up**, waiting times are problematic for most people, most of the time. **We recommend that tackling waiting times should be a major focus of regional operating plans** (Figure E-6). Wait times are measurable, understandable and meaningful to families. By focusing on this area,

particularly by using proven process improvement methods, many other issues would be identified for systematic attention. Many people suggested ways to improve access:

- **Develop a range of service options** to avoid unnecessary hospitalization.
- **Respite beds are a matter of significant concern for parents.**
- **Use the right provider at the right time with the right type of service.**
- **Create more effective linkages to remote communities**
- **Improve after-hours access**, ideally with “one-stop” access for various services.
- **Create “navigator” positions that assist parents** with accessing services.

**FIGURE E-6 TACKLING WAITING TIMES SHOULD BE A PRIORITY FOR REGIONAL OPERATING PLANS**

Waiting list management is a topic widely covered in the literature. **Regional executives need to be better informed about this issue and should make improvement of wait times a strategic priority.** In particular, we recommend:

- Effective and consistent triage processes are important.
- Centralized intake can reduce the inefficiency of multiple entry points to services. However, central intake should be monitored to ensure that new barriers are not created.
- Waiting lists need active management, with designated staff contacting families to advise them of wait times, offering intermediate support, checking whether the child’s functioning has improved or deteriorated and how the family is coping generally, and reprioritizing.
- Novel approaches are emerging to support families waiting for services for their child. This type of experimentation should be encouraged, incentivized, monitored as part of regional operating plans. A provincial think tank on this topic could identify best practices and “beacon sites”.
- Intermediate support from parent resource groups or other sources can enhance the child’s strengths as well as the capacity of the family to manage the child’s behaviour.
- Instead of relying on anecdotes, “service maps” can help track how families access the CYMH system. This then guides systematic approaches to tackle bottlenecks and gaps.
- Waiting times should be measured, monitored and publicly reported so that over time, target times for waiting can be developed, ultimately to guide resource allocation.

## **WORK WITH OTHER SERVICES TO ADDRESS COMPLEX PROBLEMS SUCH AS DEVELOPMENTAL DISABILITIES OR ADDICTIONS ACCOMPANYING MENTAL DISORDER**

CYMH provides services to children with neuro-sensory deficits, FASD, autism or substance misuse only when mental health problems are also present. We recommend that regional staff (CYMH Leads and Directors of Integrated Practice) should consider ways to reduce fragmentation of service streams and resources. We heard many stories from parents about children and youth with very high needs who are not effectively served by medical, community or school-based programs. MCFD managers are acutely aware of this problem. Several spoke of “wrap-around” approaches however, they also lamented the poor connections with HA resources and overall limited capacity. Among complex problems, the priorities are:

- **Services for children with both mental health and cognitive challenges** - although a small population, it is expensive and difficult to serve. CYMH staff received Dual Diagnosis training during 2008 with more planned for 2009.
- **Children in Care** need better coordination of support services. Closer working of Child, Family and Community Services [CF&CS] with CYMH staff could result in more effective resource use.
- **Providing appropriate services to youth with both mental health and addictions issues** is a major concern for many providers and community members. Collaborative efforts between MCFD, MoHS, and HAs are underway to improve service capacity but much work remains.
- **The children of parents who have mental illness** are vulnerable although they may not meet criteria for service in early childhood. Addressing the needs of both these latter populations will require partnerships with MoHS and HA staff.

**Many providers and community members cited the need for better partnership working.** A major problem reported by advocacy organizations is “hit and miss” coordination. We heard of successful examples of interdisciplinary working, dependent on individuals rather than systems. Appendices in the report provide suggestions for planning coordinated approaches.

## **IMPROVE COLLABORATION WITH GENERAL PRACTITIONERS AND FAMILY PHYSICIANS**

Frequently General Practitioners [GPs] are the first point of contact for families with a child experiencing any kind of physical, emotional, mental or behavioural disturbance. (Over 86% of parents responding to our survey reported that they had initially accessed their family doctor.) In some cases, the GP remains the primary support for extended periods. Therefore, **the Plan’s emphasis on improving collaboration with physicians seems sensible.** MCFD staff note that more could be done. About one-third of the Team Leaders we surveyed reported **improvement with involvement of primary care**; over half saw this as unchanged however. According to the doctors we spoke with, **communication with MCFD staff has improved since implementation**

**of the CYMH Plan.** However, this is not consistent across all regions. Education of GPs about CYMH issues is critical. Among other things, it would be helpful to explore training opportunities through the MoHS-BC Medical Association Practice Support Program.

### **IMPROVE THE COORDINATION OF TRANSITIONS FROM THE CHILD TO THE ADULT MENTAL HEALTH SYSTEM, AND BETWEEN COMMUNITY AND HOSPITAL**

Despite a decade or more of discussion about youth transitioning from MCFD to MoHS programs, nearly 80% of the Team Leaders surveyed thought this problem unchanged or worse since 2003. Even within the younger age groups, transition problems arise between hospital and community. This was also one of the most common specific problems documented by parents.

**This topic requires leadership involvement as well as expert management.**

Overall, **the parents who responded to our survey are generally dissatisfied with the communication and coordination between different service providers** (viz. GPs, MCFD, HA staff and community agencies). Only 25% said they are satisfied or very satisfied; 25% were uncertain and half are dissatisfied or very dissatisfied. These sentiments were further reflected in their inability to obtain important information about their relative, where again half of parents surveyed were dissatisfied or very dissatisfied. In general, **parents see partnerships as lacking substance and effect.**

As expected collaboration between HA staff and CYMH staff varies. We heard many examples of excellent collaboration. Unfortunately, we also heard of situations where there is no effective joint working. MCFD Regional Executives and their HA counterparts need to maintain a consistent focus on CYMH services with clear performance expectations and consequences.

### **INSUFFICIENT RESIDENTIAL RESOURCES ARE A SIGNIFICANT CONCERN**

There was no budget specifically for CYMH residential programs as part of the Plan. Not surprisingly, then, we heard frequent and strong concerns about **insufficient access to community residential programs especially for adolescents.** Over 90% of Team Leaders felt the system was not providing an appropriate continuum of residential services. Several stakeholders recommended **“step-up” and “step-down” facilities, ideally distributed all over BC.** These residential programs could offer a higher level of service than day programs, in an environment less intrusive than a hospital. A related topic was **the need for “safe houses”** to provide street youth with shelter and some basic services.

### **MAINTAIN THE FOCUS ON EFFECTIVE INTERVENTIONS SUPPORTED BY RESEARCH EVIDENCE**

This foundation element of the Plan was widely endorsed, with **95% of front-line clinicians reporting that their clinical practice is aligned with evidence-based practice.** Over 92% of

Team Leaders think that service provision has improved with the application of evidence-based practices. Staff in focus groups were also pleased with the emphasis on evidence-based practice, but cautioned that clinical judgment, relationships and community input are also important.

**Parents involved across the broad system of care reported being less satisfied with quality of care received:** 44% reported being satisfied or very satisfied. A sizeable minority (18.5%) were uncertain regarding their satisfaction with care quality, while the rest were dissatisfied or very dissatisfied. However, when asked if services had made **a positive difference in their child's ability to function, most reported some difference (61%) or a significant difference (13.4%);** only a quarter reported no difference.

Generally, the emphasis on consistent evidence-based practice shows a promising start. However, it needs **resources and leadership for continuous improvement.** In addition to leadership by CYMH regional staff, there should be provincial leadership to ensure consistency and resources for research, training and evaluation initiatives.

#### **REVISE STANDARDS TO COMPLY WITH EVIDENCE AND PROVIDE TRAINING TO MEET STANDARDS**

The CYMH Plan provided funding for two levels of core training for MCFD staff. Most have completed Level 1 Training, and good progress has been made with Level 2 training as well. Given the challenges of hiring so many new staff and managing staff turnover, **this program of training is a major accomplishment.** A CYMH training plan for 2008/09 is in development, including post-hire training for entry-level staff. Many external stakeholders commented very positively on the Plan's emphasis on training. A special concern was expressed regarding contracted services. Where feasible, training programs should be team-based and community-wide to ensure that "better practice" is consistently applied.

#### **INSTITUTE APPROPRIATE CLINICAL SUPERVISION MECHANISMS**

The CYMH Plan added new clinical supervisor positions in all regions. In the past two years, all CYMH Clinical Supervisors have been trained in a competency-based model of supervision. About 70% of front-line staff reported that relevant clinical supervision is available to them. This is a substantial improvement compared to supervision before the Plan. However, many clinicians and community groups expressed concern about the level of support available to CYMH clinicians in the MCFD Regions. Staff turnover, a concern in many communities, compounds the challenges of supervision. Therefore, we recommend on-going emphasis on clinical supervision, given the inherent risks and stresses of the work and the number of new hires.

#### **STANDARDIZE PRACTICES THAT NEED TO BE CONSISTENT ACROSS THE PROVINCE**

Some community stakeholders commented that parents, particularly those from cultural minority backgrounds have difficulty knowing how to access the system. One parent stated, "*The system*



*is so complex that you need someone to help you navigate. Professional staff don't always know all the resources.” Another said, “It's like navigating through a fog during a storm.”*

Many knowledgeable CYMH service providers suggested that **the focus on evidence-based practice must continue to be emphasized**. They recommend a more consistent approach to identifying and addressing strengths and needs, with collaborative service delivery through a team-based model. Physicians were critical of service variation across MCFD sites. One suggested that senior staff might need to lead the redesign proactively to ensure a similar structure is developed in each community.

## Chapter Five - Performance Improvement

Performance improvement initiatives strengthen the infrastructure necessary for successful implementation of the Plan and for demonstrating achievement of objectives. The improvements to information technology enable evaluation of activities, facilitate linkages with databases in other ministries and permit better tracking of mental health outcomes.

### **ESTABLISH A FORMAL STRUCTURE TO COORDINATE PLANNING AND SERVICE DELIVERY, ACROSS MINISTRIES AND SECTORS, PROVINCIALLY, REGIONALLY, AND LOCALLY**

According to the stakeholders we interviewed, MCFD's new organization structure has advantages and disadvantages for CYMH services. The positive comments relate to decision-making closer to the community-level with more opportunity for local consultation. The negative reactions arise from a fear of marginalization for CYMH; perceived loss of mandate for provincial office policy direction and accountability for CYMH services; and inconsistencies among the regional plans.

Their key concern is **coordination and management capacity to steer a large-scale initiative that involves many service providers outside MCFD itself**. Among the most pressing system concerns noted by Team Leaders in our survey is, *“a lack of regional management capacity and CYMH vision, leadership, and stewardship at the regional level”*. We observed variation across the regions in the roles of Regional CYMH Managers/ Consultants. Therefore, we recommend that **each region should have a CYMH Lead** with a specified management role as detailed in the recommendations below.

The relatively small size of the CYMH Program, within a modest BC population scattered over a vast geography also leads to **concerns about critical mass**. In developing strategy there will need to be a balance between a centralized and a regionalized approach to priority setting.

There may be some benefit in **developing an inventory of all CYMH services provided in each region**, including those funded by other Ministries and by federal programs.

Several sources commented on the **problems arising from the regional focus on child protection**. This focus is seen as not only distinct, but sometimes at odds with the needs of families with CYMH concerns. Joint training in non-clinical areas, protocols for information-sharing, agreements about access to residential resources, and shared understandings about priority referrals may address key areas of friction.

Senior leadership support is seen as lacking by most stakeholders internal and external to MCFD. The REDs that we spoke with were universally positive about the impact of the Plan and its importance in their regional strategy. MCFD managers were less clear about leadership support for CYMH issues. **MCFD leaders should acknowledge their commitment to CYMH issues, as a responsibility shared with other government Ministries, and society**. The complex web of factors that causes mental health problems is not the sole responsibility of MCFD.

**We heard strong concerns related to the lack of a formal accountability framework or quality assurance model for CYMH services**. This perception is interesting since MCFD staff have reported extensively on this issue. Nonetheless, **the absence of any formal performance monitoring mechanism remains a concern**. Some stakeholders hold high expectations for the recently created role of Assistant Deputy Minister for integrated quality assurance. Generally, there is an expectation that the regions will report publicly on investments in CYMH services.

#### **ENSURE THE INFORMATION TECHNOLOGY PLAN CAN FACILITATE PROGRAM PLANNING, SERVICE COORDINATION, QUALITY ASSURANCE, RESEARCH, COLLABORATIVE NETWORKS AND EDUCATION**

Although most external stakeholders are unaware of the information and communication technology [ICT] issues in detail, we did hear from them that communication among MCFD departments is sometimes troublesome. The greatest concerns come from MCFD staff, many of whom mentioned **problems with the new Community and Residential Information System [CARIS]**. CYMH Policy Team staff report that several issues led to incomplete implementation of CARIS. Within MCFD, accountability for implementing the ICT plan appears unclear to us. We did not review this topic in detail, but recommend **an in-depth analysis of CARIS with responsibility for successful implementation assigned to MCFD's IM/IT Branch**.

The **Brief Child and Family Phone Interview [BCFPI]** is a clinical intake screening tool also used in other jurisdictions including Sweden, Ontario and Nova Scotia. Implementation in BC started in 2005. Some managers report that they are already finding the BCFPI useful. Front-line staff are happier with BCFPI than with CARIS, although some still doubt its usefulness. Several

stakeholders observed that front-line staff should be using information management tools like BCFPI because of its capability to provide outcome data that are useful at a team, regional, and provincial level to improve our understanding of the clinical and functional profile of children served by CYMH services. **We strongly recommend continued use and development of BCFPI.**

## **DEVELOP AN EVALUATION PLAN AND COLLABORATE WITH RESEARCHERS**

We heard many positive comments about the emphasis on evidence-based practice and **the importance of on-going research to guide practice and report on results.** The partnership with the SFU Children's Health Policy Centre was specifically cited as a smart move. Several sources recommended more research based on long-term epidemiologic surveys, for example there is a need to update prevalence data for children and youth with mental health problems in Canada. (A promising example of work looking at children's mental health outcomes is the outcome monitoring study being conducted by the Children's Health Policy Unit at Simon Fraser University) **An external outcome measurement system should be developed** as a permanent resource. We also recommend a routine practice of **client and family satisfaction surveys** based on meaningful topics with direct feedback to regional managers about team performance.

The absence of measurable objectives such as targets – indeed **the lack of any formal evaluation of Plan activities - is a serious concern for many stakeholders.** We recommend that the regions should be made accountable for specific deliverables related to CYMH services as agreed in annual operating plans. We recognize that many urgent issues draw attention away from long-term planning. Therefore, each region should also be required to develop a clear and detailed implementation plan that **responds to findings and recommendations of this report.**

## Chapter Six – Conclusion

We commented earlier on **the fundamentally positive message from all the stakeholders we interviewed: The CYMH Plan presented a great vision based on a strong foundation**, and there has been a significantly positive impact on the system of children’s mental health services. That said, there was general agreement that much work remains. This is a long journey, not to be completed in only five years and requiring active engagement of partners in other ministries and community organizations. **All the stakeholders, internal and external, know that more resources will be needed; no less important is the call for leadership.** People in the field believe that a firm grip steering the system will be required to address the principles of the Strong, Safe and Supported Framework.

### PRIORITY SHORT-TERM RECOMMENDATIONS

1. **Strengthen mental health promotion and risk reduction initiatives** (such as FRIENDS and home visitation programs) through improved collaboration with other Ministries and additional resources where needed.
2. Reinvigorate the **CYMH Network Committee**.
3. There should be a commitment to **embed client and family perspectives and resources** into the infrastructure both regionally and provincially, with a policy on expectations of family advisory committees at the regional and sub-regional level.
4. Because it is a shared issue, MCFD, MoHS and MHLS will need to work closely in **detailing and rolling-out the proposed Ten Year Mental Health and Substance Use Plan**.
5. **Improved management of concurrent disorders among children and youth** requires involvement of senior staff from several Ministries.
6. **Make improved waiting times a priority in regional operating plans and involve provincial office in developing standards and recommending best practices.** We see much potential in focusing on this goal, but it will require regional leadership, a commitment to process improvement and some resources.
7. Provide **additional resources for residential facilities**, especially “step-up” and “step-down” facilities, ideally distributed all over BC.
8. We recommend **continued use and development of BCFPI. Make a business decision about continuance of CARIS.** If it is to be continued, reinforce the resources devoted to implementation of both CARIS and BCFPI.
9. Every region should have a **regional “CYMH Lead”** (exact title to be determined). This position should be part of the regional executive team, sharing authority, accountability and responsibility for the implementation and monitoring of the CYMH program with directors and CSMs.

10. The **regions should be accountable for specific deliverables** related to CYMH services as agreed in annual operating plans. Each region should develop a clear and detailed **implementation plan that responds to findings and recommendations of this report.**

#### **PRIORITY LONGER-TERM RECOMMENDATIONS**

1. Develop **an effective structure to engage partners and stakeholders** to tackle CYMH issues across government at various levels.
2. **Strengthen Aboriginal CYMH programming.**
3. Maintain momentum with **human resource development** to enhance CYMH services.
4. **Strengthen information management and research** to promote evidence-based practice, program evaluation and client satisfaction.

To conclude, we summarize the theme of several earlier comments:

**Continued improvement in CYMH services will require commitment, resources and follow-through by several Ministers and by the senior leadership group of MCFD and other Ministries.**

There are many competing demands, to be sure. The outstanding work to date can only progress if three critical factors exist:

1. **Sustainable funding;**
2. **Consistent evidence-based policy and practice;**
3. **Leadership vision and grip.**

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# Chapter One

## INTRODUCTION AND OVERVIEW

The Ministry of Children and Family Development [MCFD] commissioned this review. **The purpose** of this project was to review the Child and Youth Mental Health [CYMH] service system subsequent to implementation of the *Child and Youth Mental Health Plan for British Columbia*, identify remaining gaps in programs and services, and recommend next steps for service system improvement. **Feedback** was obtained through consultation with community stakeholders, service providers, families of children and youth with mental illness, and youth clients themselves (terms of reference are shown in Figure 1.1). The BC-based firm of A. Berland Inc. was contracted for the work.

### FIGURE 1-1 TERMS OF REFERENCE FOR THIS REVIEW

#### **Project Name**

Review of MCFD child and youth mental health service system.

#### **Purpose**

The purpose of this project is to review the Child and Youth Mental Health service system subsequent to implementation of the *Child and Youth Mental Health Plan for British Columbia*, identify remaining gaps in programs and services, and recommend next steps. The review has four main objectives:

1. To gauge the perceived adequacy of the overall CYMH service system through an assessment of the direct experiences of children, youth, and their families;
2. To identify current stakeholder perspectives on the CYMH service system in relation to priorities identified in the earlier consultation process conducted prior to the development of the CYMH Plan for BC;
3. To determine the extent to which the existing CYMH service system advances broader MCFD objectives including a) adherence to a strengths-based development approach and b) consistency with the transformation agenda including better integrated programs and services, provincial support for the regions, and improved working relationships with Aboriginal communities;
4. To determine whether as a result of CYMH Plan implementation, the system has accomplished the strategic shifts envisioned:
  - Reducing risk
  - Building capacity
  - Improving treatment and support
  - Improving performance

#### **Desired Outcomes**

- Understanding the impact of the implementation of the CYMH Plan on the child and youth mental health service system.
- Identification of remaining gaps in programs and services for children and youth with mental health issues and their families.
- Recommendation of next steps to continue service system improvements.



## 1.1 Background

The *Child and Youth Mental Health Plan for British Columbia*, [“the Plan”] approved by BC Government in February 2003, outlined new strategies to address the mental health needs of children and youth in BC. The Ministry of Children and Family Development funded the five-year implementation of the Plan through **an investment of \$44M, more than doubling the budget for Child and Youth Mental Health Services.**<sup>1</sup>

**An estimated 140,000 children and youth in the province are affected by mental disorders serious enough to affect their functioning at home and at school.** Mental health problems that begin in childhood or adolescence often continue into adulthood, causing lifelong distress and disability. BC’s CYMH Plan was the first of its kind in Canada to provide a framework and funding that recognized both the need to increase treatment capacity and at the same time achieve a greater emphasis on “upstream” strategies to intervene earlier in the lives of children before mental health problems develop.

The Plan focused on four key strategies that are congruent with the “Pillars” of the Strong, Safe and Supported Framework: (Figure 1-2)

1. **Risk reduction** – formal efforts to prevent or delay on the onset of mental health problems in children and youth;
2. **Capacity building** – strengthening the positive influence of families and communities to promote and support the mental health of children and youth;
3. **Treatment and support** – improved services to children and youth with mental health problems and their families;
4. **Performance Improvement** – creating an infrastructure to support a responsive efficient and accountable child and youth mental health system.

A key principle throughout the Plan was **the promotion of evidence-based practice** as an important means of ensuring effectiveness in all children’s mental health programs and services. This was achieved through a formal partnership with the Children’s Health Policy Centre at Simon Fraser University and the active involvement of several advisory expert panels. These mechanisms ensured the implementation of Plan initiatives adhered to best practices in children’s mental health and was informed by key stakeholder perspectives. Further, the Plan sought to address the needs of underserved populations such as Aboriginal children and children from multi-cultural groups.

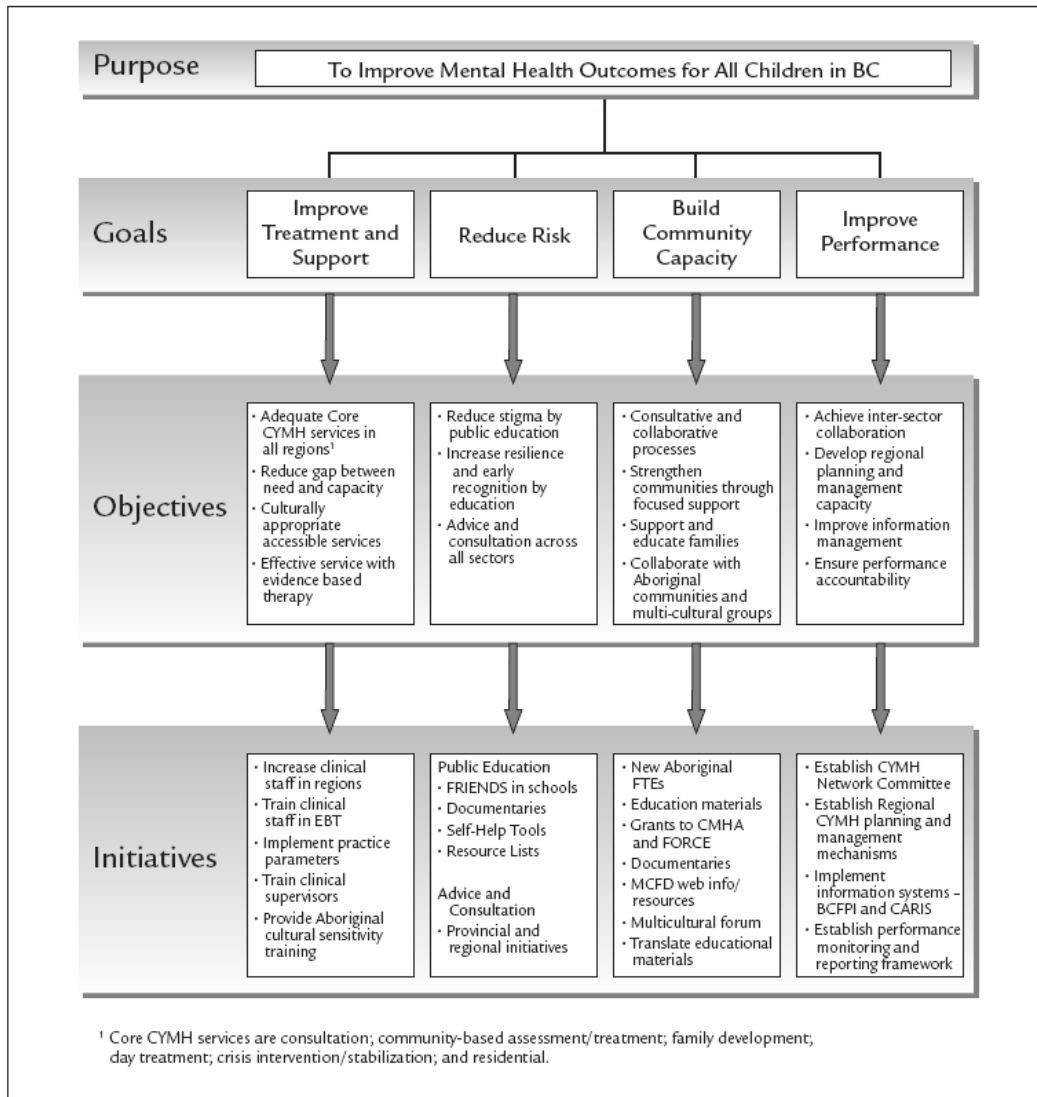
Over 90% of new annualized funding was allocated to the five MCFD regions to support implementation of Plan initiatives. The **regional allocation strategy**, based on an established socio-economic formula, achieved equity across regions and responded to variations in need. Targets guided investments in risk reduction (15%) and capacity building (15%) to support the

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<sup>1</sup> CYMH services are only a small part of the total MCFD budget, at approximately 6%.

intended policy shift toward earlier interventions. A significant portion of the Plan funding (\$10.1 million) was dedicated for services to Aboriginal children and youth. As a result, fifty-six new positions have been dedicated to Aboriginal services, with the new investments guided by regional Aboriginal planning processes.

**FIGURE 1-2 LOGIC MODEL SUMMARY OF THE 2003 CYMH PLAN**



Source: Prepared by the Office of the Auditor General (2007).

## 1.2 Review Approach

Sources of information for this review included:

- consultation with regional and provincial CYMH staff;
- focus groups with representatives of the health and education systems, community service providers, parents, youth and MCFD regional leadership teams (n=240) (see Appendix 1 for a complete listing);
- results of the CYMH consultation held in 2000 (Appendix 2)
- brief on-line surveys completed by three groups:
  - parents (*who were invited by The FORCE and CMHA*) (n=89) (Appendix 3);
  - sub-regional team leaders responsible for delivering CYMH services (n=65) (Appendix 4);
  - front-line MCFD staff (n=215) (Appendix 5);
- interviews in person and by phone with selected individuals working in CYMH or related areas in other ministries or community organizations (n=37);
- the CYMH Plan and resources including regional plans, activity reports and educational materials;
- “Strong, Safe and Supported” documents including MCFD operating plans, 2007-2012;
- numerous other documents produced by national and international service providers in this area; in particular we commend to readers the report on the CYMH Plan produced by the Office of the Auditor General (2006).<sup>2</sup> This provides much background material that we do not reproduce here.

**Limitations of this approach** need to be considered. Because most of the review participants represent a purposive sample, they may not be representative of all viewpoints. Community agencies and private practice clinicians (such as GPs) were generally under-represented in our focus groups. In addition, we are concerned that some participants’ agencies may receive operating funds from MCFD; therefore, their comments may be affected by perceptions of risk.

Nonetheless, **both the geographic scope and total number of people interviewed (n=277) and surveyed (n=369) are significant.** In addition, we encountered a general attitude of openness in discussing these matters, partly due to the condition of anonymity we promised, but also because frank expression of views appears to be the norm among these groups. Obviously, the synthesis of these multiple viewpoints is the responsibility of this author. We have made every effort to present a reasonable reflection of the various perspectives, while focusing on our deliverables regarding strategic advice about next steps.

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<sup>2</sup> Please see a complete list of references at the end of this report.

The **absence of quantitative data** from the new information systems makes it difficult to comment on CYMH Plan impact, outputs or outcomes at this stage. This situation is common to many social programs including those offered by the Ministries of Education and Health. The reorganization of MCFD programs and shift to increased regional authority, the newness of the Plan approach, and the short time frame for the review all compound the problem. Moreover, no formal performance monitoring exists for Plan activities. (The importance of good quality data is the subject of a major recommendation below.) Notwithstanding this common problem, **managers have the responsibility to make the best possible decisions based on available evidence.** We sincerely hope that this distillation of advice from the field will be helpful.

### 1.3 Report organization

We have organized this report around **the four strategic elements of the 2003 CYMH Plan:**

1. Risk reduction;
2. Capacity building;
3. Improved treatment and support, and
4. Performance improvement.

We devote one chapter to each element of the Plan, including stakeholder comments, identifying gaps in programs and services, and recommending next steps. We summarize recommendations in a concluding chapter. Appendices provide references and supplemental material.

Although our recommendations are intended for MCFD staff, we recognize that one Ministry of government is not solely responsible and cannot possibly address the issues alone. Effectively tackling the myriad challenges affecting CYMH will require **a whole community, cross-government approach with significant public support** especially against stigma and discrimination. This is a societal concern with important implications for our future.

## 1.4 Author's preface

It is the nature of reviews such as this one, to uncover or even attract various negative comments, usually about details, sometimes more substantial. In this **case, we heard overwhelming support for the Plan from MCFD staff, clinicians, advocates and family members.** People praised government's resource commitment, the Plan's direction, its emphasis on prevention and capacity building, its early cohesiveness and the follow-through. We learned that other Canadian provinces have announced CYMH plans that follow BC's lead with an emphasis on prevention, early intervention and evidence-based practice. Regarding implementation, one experienced MCFD manager commented that it is unusual for a five-year initiative to be followed so consistently through its entire course. Some illustrative comments are these:

*"The Plan was well-organized, led and implemented."*

*"The commitment to targeted outcomes and investments was very positive."*

*"Getting bogged down in the day-to-day frustrations should not blind us to the progress that has been made."*

*"The Plan was well-timed in Canadian mental health initiatives... a credit to BC... has had a lot of attention and is seen as a success across Canada and elsewhere."*

*"The Plan was an excellent vehicle with outstanding leadership from the right level of MCFD and an emphasis on accountability, at least in the outset."*

*"The Plan allows everyone on the same page regarding early intervention, a community focus and a diversified approach."*

*"What is wonderful about the CYMH Plan are the dedicated resources and emphasis on evidence-based practice that demonstrate government's commitment to dealing with issues in a focused way."*

*"A good start, much left to do"*

We do not want this **overall approval** to be lost in the constructive criticism that makes up the bulk of this report. At the same time, there is **currently a perception of stalled momentum or loss of continuity.** One community agency director commented, *"All the signs suggest that CYMH planning is not a priority. It is not a focus for MCFD [anymore]. The Regions don't want to be accountable for any new initiatives without money attached."* Others interpreted lack of information about progress with the Plan as signaling reduced interest; several asked, *"Why is government not publicizing what they did with the CYMH Plan?"*

Thus, the primary title of this report - “**Promises Kept, Miles to Go**”<sup>3</sup> – aims to convey two themes.

First, as we heard from so many stakeholders, the 2003 CYMH Plan is indeed viewed as a “promising start” (the title of the 2007 report from BC’s Auditor-General). Every stakeholder we consulted supports the approach, appreciates the new resources and values the MCFD leadership’s attention on this topic. Many feel however, that **more time, additional resources and on-going commitment are needed to realize the benefits**. One advocate said, “*Five years is too short a time. After all the effort to get our boat in the water, we ran out of sea.*”

Therefore, the second theme in our title is that there is **still a long journey ahead**. Success will require some positive, concrete steps. These steps are not all or even mostly resource-dependent. However, commitment to action is essential if mental health services for children and youth are to achieve an impact greater than the current program.

Many people assisted in completion of this task. **We are grateful to**

- The Review Project Team, Barry Fulton, Gayle Read and Sandy Wiens, for organizing the approach, gathering data and providing feedback on progress, and members of the CYMH policy team who provided information and support;
- Kimberley McEwan for preparing and analyzing the surveys of team leaders, clinicians and parents;
- Regional Mental Health Consultants, Martha Baldwin, Barry Fulton, Olga O’Toole, Yvonne Reid and Roxanne Still who provided regional data, organized focus groups in their regions and provided valuable insights;
- Keli Anderson and other volunteers from The FORCE who assisted in organizing parent focus groups and, with Bev Gutray and Canadian Mental Health Association branches, disseminated the on-line survey to parents;
- The hundreds of people who gave their time to speak with us about this important subject. Although many of the interviews and focus groups occurred during early summer, there was an excellent response, showing how important this topic is for everyone.

**We hope sincerely that this report will assist in making further improvements in the service system for children and youth, their families and communities.**

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<sup>3</sup> “The woods are lovely, dark, and deep, / But I have promises to keep, / And miles to go before I sleep, / And miles to go before I sleep.” Robert Frost. *Stopping by Woods on a Snowy Evening*.

## Chapter Two

### REDUCING RISK

Risk reduction strategies are designed to prevent mental health problems in children before they occur, delay the development of disorders, and/or mitigate their impact on functioning when disorders do occur. Strategies include both reducing exposure to known risk factors and strengthening protective factors which minimize the risk of mental illness in children and youth. Typically, risk reduction initiatives try to reach children outside of treatment settings in places such as schools.

**Provide better information about mental health problems and illnesses for communities and the general public in order that people are better able to understand, identify and respond appropriately to children with mental illnesses.<sup>4</sup>**

Overall, the people we spoke with feel that public education has been addressed very well. For instance, 83% of the Team Leaders think that education of families and the public about CYMH is “better” or “much better”. Family members who were part of our focus groups referred to materials produced provincially, while community agencies pointed to specialized materials they had produced with Plan funding. In the Interior Region for instance, the Plan funded a comprehensive service guide that was inserted in newspapers throughout the region (<http://www.kelowna.cmha.bc.ca/mentalhealthguide>).

<sup>4</sup> The shaded box headings list specific objectives from the Plan, which we have used as the organizing framework for this review of the CYMH service system. Please see the Plan for full descriptions.

The TV documentaries produced for MCFD by the Knowledge Network were cited as an excellent resource. According to Knowledge Network figures, the TV viewing audience for the documentaries was 700,000 people aged 18 and older plus a further 100,000 aged 2-18 years. There were over 19,000 visits to the associated website and 3,500 copies of the documentaries sold worldwide, with the majority of those institutional and educational sales in Canada. Parent support groups use these documentaries to educate family members, MCFD staff have shown them to foster parents and schools have used them for professional development of their teaching staff. Related web-resources provide a self-guided supplement to the documentaries. Data provided by MCFD provincial office show that uptake across Canada of a self-help workbook for youth titled *Dealing with Depression* has been and continues to be very strong (Appendix 6).

Community groups spoke of the importance of communicating in languages other than English. Parent education material has been written in an accessible, friendly style in the family’s home language. With the diversity of immigrant groups in BC, further work is needed to capture all language groups (Filipino and Korean were cited). Also all materials require constant updating as evidence progresses and resources evolve. We recommend a coordinated effort to translate materials province-wide and a system to facilitate sharing existing resources that have been translated already (e.g. by the Diversity Program in Fraser Region). We were also advised to strengthen education about anxiety in children, as this is not well recognized and often



dismissed as “just a phase”, even by physicians [GPs]. Public education about parents who suffer mental illness was also recommended.

Many agencies provide mental health information<sup>5</sup>. Multiple access points are probably helpful, but stakeholders asked about the planning behind these developments. Where staff attached to these programs also provide services to families, resources may be duplicated. This area probably warrants review and some coordination. It might be more productive and efficient to produce materials centrally, guided by close involvement of regional staff.

**Coordinate efforts to enhance protective factors, reduce risk, and intervene early in order to minimize suffering and cost resulting from mental illnesses and problems in children.**

**Within MCFD, we heard strong support for the emphasis on preventive work.** About 83% of MCFD Team leaders think that early intervention has improved, a very strong response. However only about two-thirds of them think risk reduction activities have improved, with one-third seeing this area as unchanged. Many feel the prevention and early intervention strategies of the Plan were not fully realized. They think the strategies require a greater commitment along with dedicated resources, as these are critical to stemming the flow of demand for treatment. Views about risk reduction for Aboriginal children and youth are split roughly equally between those who see improvement and those who see no change

<sup>5</sup> For example, the Kely Resource Centre operated by PHSA from the BC Children’s Hospital site advertises itself as “a provincial resource centre working to link children, youth and their families with appropriate resources in all areas of mental health and addictions.”

or deterioration. Some MCFD staff that we interviewed, while supportive of the direction, wondered whether there would be a long-term commitment from senior leaders, especially given the pressure for treatment services. One stated, *“If government really believes in this philosophical approach, they should promote it across all Ministries.”* Another recommended a clear decision-making process at regional levels to support the focus on prevention. This direction is clearly consistent with MCFD’s Strong, Safe and Supported Framework. In addition, **the regions’ recent operational plans reinforce the emphasis on “upstream” activities.**

**Generally, respondents from school districts and community agencies are well aware of the “upstream” shift in the CYMH plan and very positive about it.** Family advocates note that program criteria sometimes exclude younger children in need. Fortunately, we also heard a positive and growing appreciation of the need to develop programs that span life stages. Among health authorities [HAs] however, there was less awareness of the prevention thrust of the Plan, with Vancouver Coastal Health being the notable exception.

Ministry of Health Services [MoHS] and Ministry of Healthy Living and Sport [MHLs] staff strongly supported this objective from the Plan, although “Population Health” initiatives are new in most HAs.<sup>6</sup> In some regions, Addiction

<sup>6</sup> “Population health” is an approach that looks at all the factors that influence health rather than just looking at an individual’s personal risks. A population health approach recognizes many influences or “determinants” that affect health. These determinants include income and social status, social support networks, education, employment and working conditions, biology and genetic endowment, physical environment, personal health practices and coping skills, and availability of services.



Services already include preventive programs, as do Adult Mental Health Services. Many of the community representatives we spoke with emphasized the need for **better coordination with MoHS and MHLS to improve preventive services, especially those aimed at strengthening the early mother-child relationship**. HA stakeholders support joint efforts in these areas. MoHS staff who are developing a proposed long-term mental health and substance use plan have identified many risk reduction strategies that require joint working with MCFD and MED (British Columbia 2008a).

Many, many stakeholders spoke of the **need to coordinate preventive services across government, including risk reduction**.

One example of the need for coordination arises in the potential overlap of services for early child development. Family physicians, community nurses and MCFD staff may all work with families in the antenatal and post-partum periods. Children with FASD or autism are streamed into separate programs. Families of children with undifferentiated developmental problems may access multiple services, or conversely, not receive timely support if they do not meet criteria or experience access delays.

Parents also spoke of the need for increased emphasis on **prevention at all stages of development**. This is consistent with the emphasis on strength-based approaches to child and family services. A community provider said, *“We should wrap around that first child from the moment of conception. We should have an email address for every new mom leaving hospital. They’ve got the technology, so we should use it.”* One parent commented that prevention should be functioning at all stages of MCFD’s work in CYMH, whether in risk reduction, community capacity building or improving treatment and support.

Many others reinforced this view, citing as examples :

- pre-natal care,
- home visitation to new mothers and babies (e.g. see Wasserman 2006)
- family education about child-rearing practices,
- working with whole families when one member exhibits signs of mental illness,
- supporting children in care with prevention approaches, and
- recognizing the special needs of children whose parents suffer mental illness.

Several stakeholders said that **expanding parenting support programs at all ages**, but particularly for younger children, should be a priority. One community provider recommended rapid access to short-term, intensive parenting support in home or at another non-MCFD site. Others suggested “booster” sessions to reinforce parents’ skills. Several also noted that this is a shared responsibility with MoHS- or MHLS-funded agencies and Early Child Development [ECD] programs. Finally, some parents may need special parenting programs perhaps with more hands-on practice, along with pre- and post-sessions to ensure that parenting skills can be most effectively learned. Community agencies are strong advocates of these programs but also noted that they are expensive to operate and therefore cannot be expanded to meet community needs without added resources.

**Physicians are often the front-line for this prevention work** as they see children in early stages of problems that increase with time. One commented on the need for more resources focused on mild behavioural difficulties, particularly parenting programs. These do not need to be run by mental health professionals and could be offered close to home to be more accessible to busy families.

Several people commented that **successful effort has led to partnerships between MCFD and Ministry of Education [MEd]**, that there has been a good framing of health and education outcomes, related to an evidence-base - and that more is needed. Examples abound, including FRIENDS (Fig. 2-1), various parenting programs, “resiliency” programs, outreach support by MCFD-CYMH staff in schools, peer counselling and after-hours services. Several cautioned however, against trying to ‘shoehorn’ too many stand-alone mental health programs into schools. Instead, they argued that the leadership around mental health promotion should come from MEd.

This could be achieved by **educating teachers about concepts like resilience**, for example, that they could apply as a “lens” or perspective on various classroom situations. This integrated approach to mental health promotion would be analogous to recent developments in promoting physical activity among school-age children.

**Generally, school district staff support more “joint ventures” with MCFD, through co-funding and co-management of programs.**

## FIGURE 2-1 A SUCCESS STORY - THE FRIENDS PROGRAM

**FRIENDS a strength-based, resiliency-building program, was most commonly cited as an example of upstream work and is widely seen as extremely helpful.** School district stakeholders have excellent opinions of the program. Family advocates also view it very favourably, only adding that some parents would like FRIENDS offered earlier. One school district staffer described using FRIENDS as a “pre-screener” and for educating families. The FRIENDS approach has also created a common language among teachers. Throughout this review, teachers in our focus groups agreed strongly that MCFD should promote the FRIENDS program vigorously.

### CHALLENGES WITH THE FRIENDS PROGRAM TO DATE

- **Training costs are a problem**, particularly funding teacher release time. Some districts offer training during district professional development days, and in late afternoon or evening sessions.
- **Program uptake is low** among some school districts across the province.
- **In some cases, program fidelity is uncertain** - whether teachers are delivering the structured program as it was taught at the 1-day training workshop, and how student workbooks are used.
- MCFD staff report that they are just completing consultations with stakeholders to understand **key factors that influence the uptake and sustainability of FRIENDS in school districts**. Results will be completed in summer 2008 with an action plan following.

### TAKING FORWARD THE FRIENDS PROGRAM

- Many school districts have a **FRIENDS liaison**. In addition to communications and coordination of local training events, these individuals help to promote the program with teachers in their district.
- **Joint communications about FRIENDS from MCFD and MEd** are sent to Superintendents, Principals and Special Education Coordinators at the beginning and end of each school year.
- **Program materials have been translated into French** for use in September 2008.
- **The FRIENDS Youth program, targeted at Grade 7**, will be introduced in 2008-09, and will be reviewed at the end of that school year.
- **The FRIENDS Aboriginal research project** will be completed in 2008-09.
- **FRIENDS parent workshops** will continue to be delivered in 2008-09, in collaboration with The FORCE
- MCFD staff will meet with Regional CYMH Managers/ Consultants in fall 2008 using the focus group findings to develop a **plan to enhance implementation of the FRIENDS program**.

## Recommendations related to risk reduction

1. **Strengthen commitment to mental health promotion and risk reduction** at all stages of child development, including provision of additional resources where needed.
2. **Improve collaboration within MCFD and with other ministries** on mental health promotion and risk reduction initiatives. For example:
  - a. Work with the MoHS, MHLS, Health Authorities and MEd on initiatives related to early child development and parent-child relationships such as home visitation programs (Wasserman, 2006).
  - b. Collaborate with the MEd to implement evidence-based mental health promotion programs in a more consistent and comprehensive manner. This should include strengthening the implementation of the FRIENDS program in schools throughout BC.
  - c. Coordinate efforts around public education programs including translation, distribution, and updating of web and video materials, and education about parents with mental illness and anxiety in children.
  - d. Coordinate, expand, and improve access to a continuum of parenting support programs including programs for parents with young children
  - e. Increase targeted mental health promotion initiatives for particular populations including children in care, children with undifferentiated developmental problems, and Aboriginal children.

## Chapter Three

### BUILDING COMMUNITY CAPACITY

Capacity building initiatives are designed to create environments that foster mental health, support children with mental disorders, educate the public, and decrease stigma associated with mental illness. The capacity building strategy comes from the understanding that a variety of biological, social, psychological, economic, and other environmental factors influence mental health. Within this context, MCFD staff design initiatives to support and strengthen the positive influence of families and communities on the mental health of children.

Provincial initiatives to build capacity focus on resources that benefit the communities, families and the public across the province. Regional efforts to build capacity are broad and varied, and developed in response to the unique needs and existing resources in local areas.

**Provide better information about mental health and mental illness for communities and the general public in order that people are better able to understand children with mental illness.**

First things first: **The capacity building efforts of the CYMH Plan are widely supported as an excellent approach - progressive, relevant and timely.** For instance, over 75% of the MCFD Team Leaders reported improvements in community capacity to manage CYMH issues. Even amongst those who stated that there is still much work to be done, there was universal support for the Plan's approach towards community capacity development. This is seen as congruent with strength-based services and the five pillars

of MCFD's Strong, Safe and Supported approach. Some stakeholders stated that **the Plan gave them a sense of renewed hope and faith in the government's commitment** to this issue.

We heard of various **community-oriented training programs**. For example, some community groups used CYMH Plan funding to provide the Canadian Mental Health Association's "Mental Health First Aid" courses for community groups including firefighters, chamber of commerce members and staff from the Child Development Centre. In another instance from BC's North-west, the Plan funded training for staff working in several remote First Nation communities. These programs increase skill levels in identifying problems and referring children and youth.

**In our view**, promoting or "mainstreaming" the prevention of mental health problems should be fundamental to all aspects of MCFD's work. Addressing these issues early has the potential to improve life for that individual, of course. In addition, it affects parents, siblings, extended family and the community of students, neighbours and friends. Moreover, untreated mental health issues in later life may affect parenting that impacts subsequent generations. Addressing social stigma towards mental illness increases the likelihood of early intervention and effective support. Therefore, **training in identification and collaborative management of mental health issues should be intensified among key**

**community service providers** such as MCFD staff in other program areas, health and early childhood professionals, schoolteachers and crisis responders such as firefighters and RCMP officers. Programs would obviously need different depth and scope to meet varying needs, such as Youth Justice staff and judges and lawyers involved in youth issues. To compare, in BC today, workplace activities are guided by a general and specific awareness of worker safety, with an emphasis on responsibility at all levels of the organization. Similarly, the “lens” of mental health promotion should continue to be a cornerstone of MCFD’s public education strategy. This should include focused programs for key groups:

- MCFD staff, including executives and direct service personnel;
- Community nurses and GPs;
- Novice social workers and teachers through programs aimed at university students;
- Police officers, fire fighters and other crisis responders.

Some stakeholders urged recognition of **the important role played by the private sector**, particularly influential individuals with relatives affected by mental health tragedies. In some cases, corporations concerned with family and work-life balance, have implemented programs and track mental health improvements, workplace well-being and productivity.

**Work in partnership with the broad range of child and family supporting organizations traditionally located outside of the formal mental health system.**

The 2003 Cabinet Submission described **collaboration with other Ministries as “a critical element of success in the implementation of this Plan,”** (p 42). In

particular, the Plan identified a need to improve partnerships with MoHS, Health Authorities [HA], MEd, school districts, physicians, teachers and other system partners. Most stakeholders we spoke with agree that partnerships across government but especially between MCFD, MEd, MoHS and MHLS are a priority concern. Rarely mentioned, but of special significance for Aboriginal communities are **programs operated by federal government agencies.**

Over 97% of front-line MCFD-CYMH staff who responded to our survey reported that they routinely coordinate with child welfare, school districts, and public health services. This outstanding response shows **the importance placed by clinicians on these partnership efforts.** (Unfortunately, parents view efforts at partnership quite differently. We discuss their views below in Chapter Four, since most refer to treatment and support issues rather than community capacity building.)

**CYMH Policy Team staff report** that they have developed several initiatives with other Ministries, particularly with MoHS, MHLS, HAs, MEd and School Districts. These **inter-ministerial projects include the following:**

- MCFD and HAs have established protocol agreements in every region to facilitate transitions for children and youth with mental disorders between hospital and community-based services, and from the MCFD system to the MoHS system.
- MCFD and MoHS are working jointly on Youth Concurrent Disorders. So far, surveys and consultations have been used to develop
  - a description of current services;
  - curriculum for staff training and support needs, and

- a concurrent disorders network involving MCFD, MoHS, and HAs that will work on systems improvements such as consistent clinical screening and referral processes, and training programs.
- MCFD and HAs are collaborating in the delivery of services related to infant mental health and concurrent disorders in some regions.
- MCFD, Provincial Health Services Authority, HAs, MoHS and community partners are working together to develop a Suicide Prevention, Intervention, Postvention Framework for BC.
- A Provincial Inter-Ministry Working Group, co-funded by MOH and MCFD led the development of the Early Psychosis Intervention [EPI] Initiative. This cross-sector group initially developed best practices guidelines and an EPI training program. The training, which includes on-site training at the EPI Centre in Surrey, a web-based module, and long distance consultation, continues through an MCFD and MoHS partnership.
- MCFD and Schools Districts are collaborating to fund school-based mental health clinicians in some regions.
- The First Nations Schools Association [FNSA] and First Nations Inuit Health have collaborated with MCFD to deliver FRIENDS training to FNSA teachers and parents throughout the province.

**The Child and Youth Mental Health Network deserves special mention.** This committee includes senior representatives from MCFD, MoHS, MHLS, MEd and others. It meets three times a year with a mandate to coordinate service delivery and

to identify and resolve service coordination issues. Early in the implementation of the CYMH Plan, stakeholders told us, the Network was seen as an excellent forum for exchange of information with a very broad range of community participants. However, we heard from several members that the Network is now seen as ineffectual, unsuitable for decision-making and lacking a clear focus. We heard several explanations: the move to greater regional influence; a shift in participation by key members; and a drift in focus as the CYMH Plan is winding down. MCFD staff advised us that Network members are now revising Terms of Reference. Stakeholders want the Network to serve as a place where key decision-makers can “*agree to work together, sometimes outside their traditional mandate*”.

In years past, most MCFD Regions have had **mental health advisory committees**, typically including staff from other MCFD departments or teams, HAs and School Districts, and occasionally families. Few exist today. Similarly, at the sub-regional level, joint working groups operate in certain areas, but not in all. These include ECD, integrated case management, community advisory committees among others. Some informal groups also work on an interagency basis. Where joint working groups operate, some report out routinely and widely, while others do not seem to report to stakeholders who are not at the table.

**In sum, this important work appears inconsistent – occasionally excellent, sometimes under-managed.**



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## MCFD AND MINISTRY OF EDUCATION NEED TO WORK MORE CLOSELY

**Partnership work with school districts should be a priority.** We heard from family advocates that schools are often parents' greatest concerns because they know their children need to be in school to ensure future success. They recommend more access points for CYMH services in schools: *"That's where the kids are; that's what makes their life meaningful. [However] that door is often closed. The safety net is not there in schools."* The parents we spoke with were generally negative about their experiences with school district staff. They are concerned that restrictive policies in school have reduced openness to any behaviour seen as disruptive.

On the other hand, we also heard of **many positive partnerships**. Some BC school districts are working with MCFD to address CYMH issues using the School-wide Positive Behaviour Support program (Sugai and Horner, 2006). The most comprehensive example we heard was in New Westminster, where several collaborative ventures are underway: A "Partners Committee" of Fraser Health, the School District, United Way, City and MCFD have agreed to create a "hub" for early child development [ECD] using pooled funds. They have also written Collaborative Practice Guides describing integrated case management for both service providers and for parents. In the North, we heard positive reports about the joint work on Complex Developmental Behavioural Disorders by HA, MCFD and school district staff.

Notwithstanding these excellent examples, we also heard of **inconsistent collaboration between School District staff and MCFD staff** (or MCFD contracted agencies).

Alternate high school programs, for instance, where many vulnerable youth attend, are often a good venue for partnership programs. However, a school district principal cautioned, *"We need partners who are familiar with working within a school building. It is not the same as office work."* One community reported weekly meetings in the school where students discuss mental health, substance use and general health issues, in a program shared with RCMP and HA staff. However, this occurs inconsistently. In another region, we heard that multiple programs exist in some schools (with twenty-six in one "program crazy" situation).

**Attendance of MCFD staff in schools requires discussion at a provincial level to develop clear guidance for local collaboration.** School district staff reported difficulty getting MCFD staff to attend at schools. *"Sometimes it feels like we [schools] are calling out for help, but we aren't getting a reply,"* as one school district principal told us. On the other hand, we also heard of local resistance and concerns of the teachers' union regarding MCFD staff working in schools. This important issue requires clarification. As one school district official stated, *"Schools tend to be a self-contained 'bubble'. We need the presence of mental health clinicians in our schools. They normalize CYMH issues. This is some of the best-spent money in the whole system. We must reduce resistance to allow outsiders into the bubble."* The school district stakeholders we spoke with are clearly concerned about CYMH issues, traveling to speak with us during summer break. Yet, they recognize **the difficulty of getting complex systems to work together.** One



stated, “Nothing will change without a mandate to collaborate.”

Many parents reported that teachers often lacked knowledge about CYMH issues. “Teachers blame the parents and blame the kids,” said one parent, “but they don’t offer any help.” Many parents and providers recommended that **teacher education and professional development programs should inform educators about CYMH issues**, especially early identification, communication with families and how to access resources. Teachers, we were told, sometimes feel that they do not have the skills to manage CYMH problems; some speculated that this might explain some teachers’ reluctance to offer the FRIENDS program.

School district staff would like to see a greater emphasis on continuity in the classroom environment.

Shared language and understanding of how to access resources and work with each other would speed up the time needed for MCFD and school district to work effectively together. At the local level, a school district representative recommended these steps to make interagency meetings more effective:

- an informal process;
- pertinent to what is happening with youth in the region;
- help practitioners work together on an expedited informal basis;
- allow for the sharing, not duplicating of resources;
- be action oriented, focus on evidence-based practice and how to do this feasibly.

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## MCFD AND MINISTRIES OF HEALTH NEED TO WORK MORE CLOSELY

At the level of policy and planning for CYMH, both Ministries of Health play significant roles. Presently **work is underway in MoHS and MHLS on a proposed Ten Year Mental Health and Substance Use Plan for the province**. MCFD is seen as a “co-lead” on this project and many partners (including a dozen different provincial ministries) are involved. While still in the conceptual stage, this plan looks up- and down-stream, at mental health, substance abuse and risk reduction, with promotion, prevention and treatment components. The MoHS/MHLS plan takes a life course approach, so is not for adults only. The aim is to integrate across all Ministries’ plans, taking a whole system, whole government approach. This obviously

has important implications for MCFD, requiring involvement of policy staff. Several people suggested that **MCFD should be actively involved in the Ten Year Plan development**, including communication amongst MCFD stakeholders, with regional executives taking a more proactive role.

As noted previously, the concept of population health is relatively new to many health professionals. As a result, HA staff sometimes discount the determinants of mental health problems in children and youth. One psychiatrist questioned whether any problems can be “prevented”. MCFD staff working with health professionals need to **ensure that other service providers**

**understand the role of social determinants of health in contributing to the development or exacerbation of some mental health problems.**

MoHS/MHLS and HA staff observed that the MCFD Plan’s “upstream” work requires **integrated planning** for early intervention. They asked, “*How has the CYMH Plan supported upstream collaboration?* This might include, for instance, closer involvement by CYMH staff with the early assessment work of Public Health Nursing. An ECD provider commented on the complex work of pre natal care, “*They need to cover so much – attachment, stress levels while in the uterus, parent nutrition – it’s not just about how to breathe during labour.*” In some sub-regions, there are agreements promoting collaboration - for instance in North-west BC staff have jointly developed protocols for acute response and coordination of intake including care pathways - but we were told these are isolated. We also heard of a few instances of CYMH services co-located in Child Development Centres or community “hubs” with excellent reports.

**Youth addictions services are an example of a complex multi-system program.** Many youth present with concurrent disorders and

thus require services from both Ministries. Presently this is difficult to arrange; providers told us the services are “fragmented”, subject to “turf wars”, with few mechanisms to compel collaboration. The initiatives noted above may begin to address these concerns, but this topic needs attention from senior staff. Specifically we would recommend the following approach to youth addictions:

- an ADM committee on child and youth addictions;
- joint development of common program objectives and priorities
- tied inter-ministry funding for programs as well as projects;
- common and regular reporting out on activities, spending and priorities.

**More generally, funding from both Ministries could incentivize projects that encourage joint working.** Any new funding could be directed to shared projects requiring collaborative planning and evaluation. For instance, joint training for HA and MCFD staff could improve joint working and application of evidence-based practice. We discuss this point further below.

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## CYMH ISSUES NEED CLOSER COLLABORATION RIGHT ACROSS GOVERNMENT

Government officials recommended that in addition to program delivery, **MCFD, MEd, MoHS and MHLS need to work jointly with other ministries to identify policy levers.** For example, shifts in policy to address alcohol marketing, access and consumption can improve community mental health – with lessons to be learned from tobacco control. Government insiders also cautioned that Ministries draw boundaries around their mandates, usually based on resources. Difficulties with collaboration may have nothing to do with lack of good will or confusion over mandates, but with resource allocation. It is very difficult to reach agreement without resource commitments, and even if possible at the executive level, tough to deliver on the ground.

A community stakeholder noted that income supports and appropriate housing are important adjuncts to services for youth. Earlier support to prevent homelessness can help youth avoid problems later in life. This may require **specific initiatives linking with the Ministry of Attorney General and Ministry of Housing and Social Development.**

In many communities, **contracted and other community service agencies are a critical component** of delivering responsive, community-oriented CYMH services. Generally, these groups reported good knowledge of initiatives funded by the CYMH Plan, and were well aware of other MCFD work in the field. Many reported that their staff had received training alongside MCFD staff in topics such as CBT or DBT. **This shared training is highly valued and promotes inter-agency collaboration.**

However, in some cases, agency staff were not included in new training initiatives. We also heard from many community groups about **privacy concerns that unnecessarily block information sharing between service providers.** The agencies also expressed a desire for formal and informal ways to **strengthen relationships** through role-clarification activities, inter-agency committees, and joint projects.

Community groups like the Canadian Mental Health Association, BC Schizophrenia Society, The FORCE, Mood Disorders Association, faith-based groups, multicultural groups, social service agencies and others are involved both formally and informally with MCFD's CYMH activities.<sup>7</sup> Some stakeholders commented that although client case management often works well, **contracted and community service agencies would like more structured involvement in sub-regional planning and program development.** The community groups are particularly effective at stretching small sums of money. Unfortunately, because of wage differentials, some of these groups lost staff to Plan-funded opportunities within MCFD's wage structure. Meanwhile, some providers noted that community agencies sometimes work at cross-purposes or in direct competition for clients. All these beneficial and unintended consequences might be better tackled with coordinated planning at the sub-regional level.

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<sup>7</sup> Among other groups cited were Boys' and Girls' Clubs, Big Brothers, Big Sisters, Community Living BC, Neighbourhood Houses.

In sum, much good cross-government and cross-agency work has occurred; even more is required. Stakeholders stated that **leadership from Ministers and throughout government is necessary to bridge the inter-ministerial silos that affect CYMH.** Staff at all levels need to know that “cross-fertilization” is valuable and supported. Executives from MCFD, MEd and MoHS/MHLS should champion and scale up the good examples of collaborative work. MCFD is the “first mover” on issues related to CYMH. Within the Regions, MCFD Directors of Integrated Practice appear well positioned to make the necessary linkages at the regional level.

**Fully involve families (and children when they are able) at all levels of planning and delivery of services.**

This objective from the CYMH Plan includes two important components. We will first address family involvement in service planning, which addresses the needs of groups of clients from a program planning or business operations perspective. Then we will tackle service delivery, which is assessment, treatment and evaluation services provided to individual clients or families.

**In some sub-regions, parents are part of CYMH team planning and business meetings.** Certainly, some communities have benefited from Plan funding for parent groups. The FORCE is the most active of these groups, with chapters in several Lower Mainland communities, in Victoria and in Penticton. On the negative side, a provincial External Advisory Committee involving families and advocates was created in the early years of the Plan; this has been inactive recently, although some of its members continue to meet. However, there

is currently no formal voice for families at the provincial level. Replacing the Advisory Committee would probably be helpful.

**In some regions, Transformation Reference Groups operate,** but these are not seen as a forum for families with CYMH concerns. Parents sit on various committees but there are few venues where family members can provide input to policies and plans. One stakeholder commented, “*This is inconsistent .... Sometimes, families have to fight to be heard.*” In the four parent groups held during this review, none of the participants had ever been asked to provide feedback about services. We recommend additional support for this important resource.

CYMH Policy Team staff report that they have formed a provincial working group related to family engagement and interventions as a sub committee of the CYMH Policy Advisory Committee. In addition, they recently distributed a survey to CYMH staff to determine their level of engagement with families and their training needs related to working with families. Further steps will follow the results of that survey.

**Generally, Health Authority [HA] involvement of families in planning of CYMH services is also described as weak** by both providers and parents. Overlap between MCFD and MoHS processes is also a problem. Service providers spoke to us of their desire to include families more in planning their services; parents felt left out. This would be a good area for collaboration between HA and MCFD teams to ensure that requests for participation do not place undue demands on parents and youth already coping with many stresses.

Regarding service delivery, **family involvement in individual assessment,**

**treatment and evaluation is seen as “hit-and-miss”.** With regard to their ability to be involved in the care planning for their son and daughter, two out of five parents or guardians responding to our survey (41%) were *satisfied* or *very satisfied*, 38% were *dissatisfied* or *very dissatisfied*, and 21% were *uncertain*. In some areas, families are involved by mental health teams, for instance to provide education and support to parents. However, we have no evidence that this occurs in all sub-regions. The FORCE representatives suggested that they could provide more support to parents, for instance:

- to accompany new families to Integrated Case Management meetings;
- to teach parents how to advocate for their children;
- at the initial referral after intake screening, to provide support and system orientation while parents wait for clinician services;

- to connect families for peer mentoring;
- to provide education sessions for families.

**Parent resource groups deserve special mention.** This is one way to mitigate distress while families wait to have their child seen by mental health clinicians. Presently, these operate in some communities through The FORCE; we also heard of parents’ mutual aid groups offered by Early Psychosis programs. In other communities without such supports, parents suggested to us that they would welcome this arrangement and would participate. They recommended calling these “Parent Resource Groups”, rather than “Support Groups”. Although the financial support required is modest (childcare and transportation costs), this is important for many parents.

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**FIGURE 3-1      WHAT YOUTH TOLD US**

*If I need help, I must track it down. They [MCFD CYMH] need to put it out there, because people don't know that it exists.*

*Once you get in things are pretty dandy - once you have finally crawled in and claimed your spot. But getting in is a whole lot more work than it needs to be.*

*Talking to a counsellor would have been a whole lot easier if I had done that earlier on.*

*Students provide a lot of good information to other students. They need more mental health topics.*

*There should be information about mental health everywhere - on planes, in magazines, on the radio - with phone numbers about how to get help.*

*Privacy is not my priority. I want my counsellor to share my personal information [with other clinicians who need to know], unless I tell them not to.*

*What we learned from our CBT groups was self-confidence in talking in front of groups; how to hear as well as how to speak; mutual support, especially as I saw how others progressed; not to make judgments about other people; how to measure what is “normal”.*

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**Education programs can help to involve parents in service delivery.** The Maples' Connect Parent Program is widely valued. Both providers and families recommend more “whole family” approaches rather than treating the child in isolation. We observed that many agencies offer programs aimed at better parenting - so many in fact that the proprietary names can be confusing.<sup>8</sup> A community-oriented parent education program is very different from a program to support parents whose children have mental health issues. We recommend standardizing the nomenclature and clarifying the purpose of these “parenting programs” at the provincial level, through a cross-ministry initiative to improve access, costs and quality. This would also help to engage parents in a stepped process for appropriate levels of support and would keep the language more consistent when families move around BC.

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**FIGURE 3-2      WHAT PARENTS TOLD US**

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*Support in school for kids with CYMH issues seems to vary within and across school districts. It seems to depend on each principal whether that support is a priority.*

*If we didn't get these services, my son would not be able to function. It has helped him immensely.*

*Why don't all community health nurses check for parental mental illness when they visit families with newborns?*

*GPs and even pediatricians are woefully undereducated in children's mental health issues. These professionals made things worse by... causing me to question my own parental instincts.*

*What happens to the kids whose parents cannot advocate for them?*

*How do we help parents become strong advocates who can help teachers to provide programs that work for their kids?*

*I'm just happy I found a support group to help me through things.*

*I had no idea there was such a thing as Child and Youth Mental Health.*

*No one seems to know who has the key to the door – and in some cases they don't even know that a door exists.*

*I had no idea that I was eligible for the Child Disability Tax Credit until I found out at a meeting of The FORCE. Why don't MCFD staff tell parents these things?*

*We are tired and we want someone else to be responsible and tell us what to do, rather than us telling them what we need all the time.*

*Some labels get you into the club. If you can you try to get your child reassessed with a better label. The difference between a child with mental health issues and “a bad kid” is a diagnosis.*

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<sup>8</sup> For instance we heard of Bifrost, Connect Parent Headstart, Helping our Children Learn, Incredible Years, Make Children First, Parenting Actively Now, Parenting your Anxious Child, Parenting Wisely, Strengthening Families, STEP, Triple P Parenting, and others. Probably there are important differences to those knowledgeable, but one parent compared this proliferation to the diet industry.

*Working with whole families needs further emphasis, not parceling out little pieces. We need to bring systems and families together.*

*Many grandparents are raising kids – who is supporting that person?*

*Parents are back to being the [forgotten] “foster kid” again after being involved for five years in planning and implementation.*

*What we need is a “one stop” place for diagnosis (in a quick manner) and access to coordinated care that is able to do follow-up and provide immediate service where needed.*

From the on-line survey, the most common specific concerns regarding the provision of mental health services for children and youth documented by parents were as follows:

- Difficulties accessing appropriate care and long-wait times for service;
- Insufficient support to navigate a complex formal care system and to secure services which were appropriate to the client need;
- Lack of coordination among providers within the system;
- Limited information for families and inadequate communication;
- Transitioning from youth to adult mental health services;
- Limited opportunity for early intervention so that problems progress.

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Several providers noted that **addressing the educational needs of foster parents is particularly important**. They may lack knowledge about CYMH issues. The standardized training available to foster parents is rudimentary on this topic. The foster parents themselves have a range of capabilities and needs, and often feel disconnected from the service system. Providers see them as very open to receiving more support but lacking any “gateway” to training.

**Co-location of CYMH services with child protection is problematic for parents**, according to both providers and community members. One provider recommending more outreach stated, *“We should go to them.*

*Coming into a scary building where kids are apprehended is a big deal.”* A parent said, *“People need reassurance that walking in here for help won’t result in losing their kid.”* Moreover, some parents fear revealing their own mental health issues. The forensic system addressed similar concerns by clarifying the boundaries between probation officers and clinicians. This approach might be instructive. Several Aboriginal service providers commented that MCFD-funded liaison workers were doing an excellent job of building trust by explaining the difference between CYMH and Child Family and Community Services [CF&CS] functions<sup>9</sup>.

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<sup>9</sup> Child Family and Community Services programs are mandated under the Child Family and

MCFD's Report on the Sexual Abuse Intervention Program (McEwan 2006) noted that "many families are 'system wary' and would only access treatment services for their children if available in community settings — outside of government offices" (p 18). In many cases of course, CYMH services are delivered in separate offices or through contracted agencies. However, where they are co-located with other MCFD programs, changes may be helpful. In some communities, child-serving agencies have developed children's centres, often using disused school buildings. This community-based setting can help to normalize access and focus on the promotion of health and well-being for children and families.

We recommend **consideration of alternative placement of CYMH services away from child protection functions to enhance accessibility.** We recognize that this appears inconsistent with other recommendations calling for greater coordination, cooperation and integration. However, although physical co-location is helpful, this is not a prerequisite for cooperation. The extra hassle for staff can be mitigated with electronic communication and process improvement methods. The perception of families is much harder to shift.

**Some populations may need different approaches for effective service.** For instance, the system is not seen to encourage peer support for youth. Although involving youth can be challenging, stakeholders, including youth that we spoke with, suggest that MCFD staff continue to explore ways to engage youth in planning relevant programs. We also heard that some multicultural populations may not receive adequate services, in part due to stigma attached to

mental health concerns. The Plan funded much good work on this, but given the substantial burden of community needs, we recommend capacity building with these groups.

#### Support Aboriginal mental health.

Despite the many issues yet to be resolved, many stakeholders told us that **the strategic focus on Aboriginal mental health is a very significant step forward for MCFD.** The most important accomplishment of the Plan in this area was the allocation of funds specifically targeted at improving the mental health of Aboriginal children and youth. As part of the Plan, a significant part of the increased funding (\$10.1 million) was dedicated specifically to services for Aboriginal children and youth.

Further collaboration and planning for improvements to Aboriginal CYMH services is underway in the larger context of the MCFD Strong, Safe and Supported Framework. **Regional Aboriginal Planning Committees developed plans that are now being implemented** in Fraser, Interior, Vancouver Island, and North regions, while Vancouver Coastal region plans are being finalized. Although hiring is not yet complete in all regions, seventy new positions have been dedicated to Aboriginal services, including Aboriginal Team Leaders, Outreach Clinicians, Community Outreach Workers, and Aboriginal Wellness Coordinators (Figure 3-3).

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Community Services Act which provides a range of measures to ensure children are protected.



**FIGURE 3-3 NEW POSITIONS FUNDED BY THE PLAN FOR ABORIGINAL SERVICES**

REGION	Clinical Generalist	Clinical Specialist	Support Worker	Unspecified	REGIONAL TOTAL
FRASER	8	-	10	-	18
INTERIOR	7	-	-	-	7
NORTH	7	-	11	7	25
VAN.COASTAL	1	1	-	-	2
VAN.ISLAND	10.3	-	8.5	-	18.8
<b>PROVINCIAL TOTALS</b>	<b>33.3</b>	<b>1</b>	<b>29.5</b>	<b>7</b>	<b>70.8</b>

**Other initiatives in this part of the Plan included:**

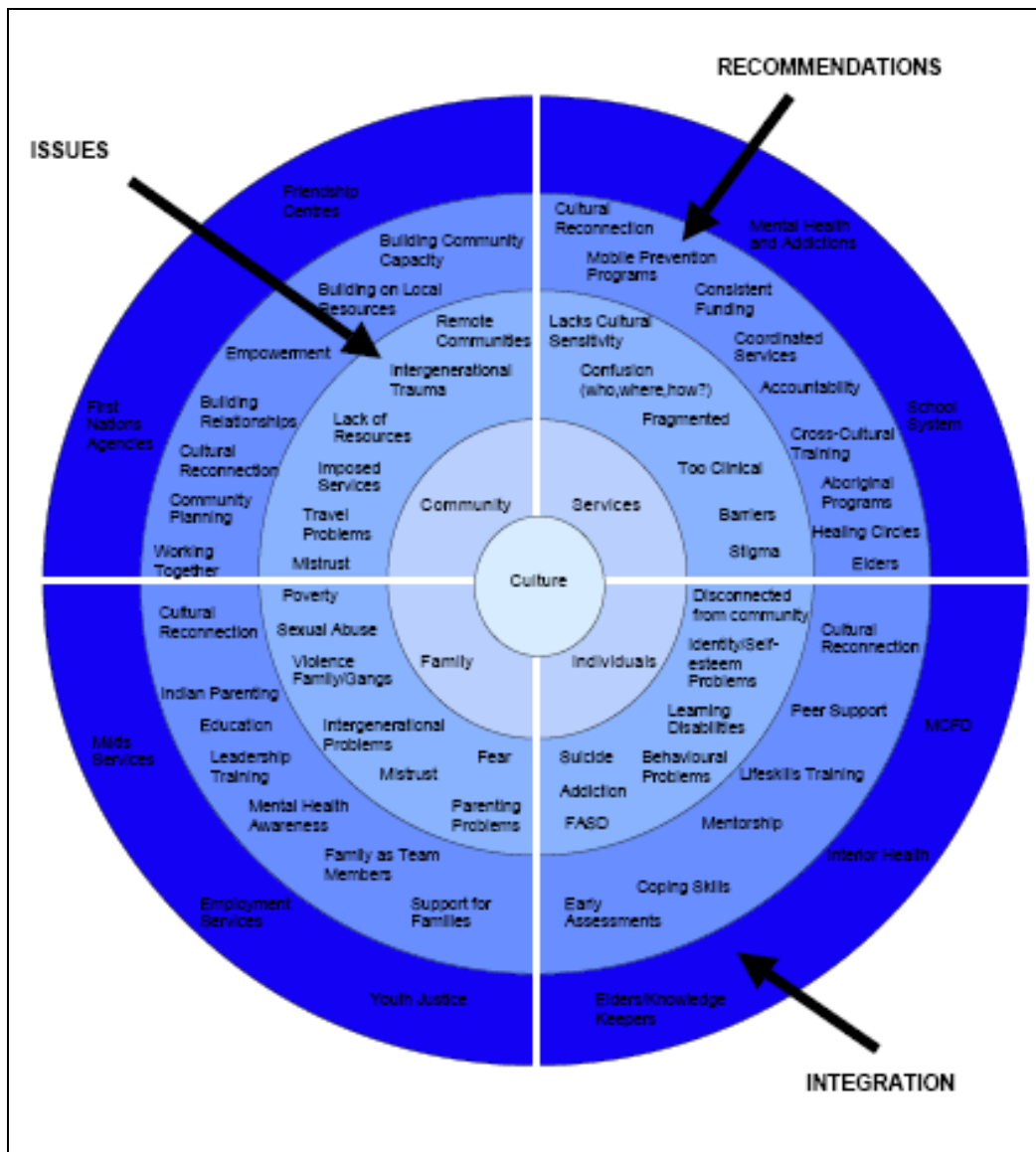
- Several one-time grants totalling \$1 million to support planning and training for Aboriginal service providers in the North;
- The North has also implemented the Loomsk Life Skills Development program, a school-based prevention program for Aboriginal youth.
- Programs aimed at increasing the coping skills of Aboriginal children and youth and Aboriginal Community Suicide Intervention Response Teams (ACSIRT) are being implemented in several communities in the Interior region.
- An Aboriginal “Strengthening Families” program has been delivered by Aboriginal facilitators in Vancouver Coastal region.
- The FRIENDS program is being adapted to be culturally relevant for Aboriginal children and youth through a research project undertaken in partnership with UBC.
- CYMH is also collaborating with First Nations Inuit Health and First Nations Schools Association (FNSA), teachers and parents to deliver FRIENDS to FNSA elementary students throughout BC as part of a suicide reduction strategy.
- About three hundred clinicians in the Interior, Fraser, Vancouver Island, and Vancouver Coastal regions have attended mandatory training on Aboriginal cultural sensitivity.

To the question, “Is there consistent and effective involvement of Aboriginal communities in service planning and delivery”, most respondents in our focus groups said “Yes, but not consistently.” Some staff commented that **provincial leadership around Aboriginal CYMH is unclear**. Overall, there appears to be a widely shared opinion that there have been **significant gains, but much work remains**. In some regions, foundation issues need to be recognized (see also Figure 3-4):

- The diversity among First Nations;
- Difference among the communities in terms of economic and social conditions;

- No history of working relationships among providers;
- Service overlap among providers;
- Varied understanding about mental health issues.

**FIGURE 3-4 AN INTEGRATED APPROACH FOR ABORIGINAL CYMH SERVICES**



Source: Interior Region, MCFD (2006). Aboriginal Child and Youth Mental Health Plan

**A key theme** we heard about is the issue of **balancing Aboriginal views of mental health with appropriate medical supports for certain psychiatric disorders**. Many of the root causes of mental health problems for Aboriginal children and youth arise from the intergenerational effects of racism and the residential schools experience, which resulted in family dysfunction, leading on to multiple losses due to trauma and separation. In addition, mental health concerns such as anxiety and depression may be compounded by FASD, autism, and other disorders, along with concurrent problems of substance misuse. Addressing these issues requires an understanding of cultural and community approaches that can be challenging for anyone and especially for novice front-line workers. We heard from some stakeholders that medically oriented approaches are not always viewed positively and that psychiatric practice is sometimes seen as “labelling”.

Another theme that we heard from stakeholders is the importance of **accepting influence from the community itself**, so as to ensure that services offered are appropriate and effective. This also means ensuring that other children’s service providers, such as schools, are involved. For instance, one Aboriginal Services Manager described trying to support professionals already involved in treating a child or youth, so that a continuity of relationship is provided. Otherwise, there is a problem with too many different professionals, each with their own expertise or background, assigned to a client and the client feels ‘buffeted’ about in the system.

At the system level, we also heard a preference for **community-specific services that are consistent with the principles of the Strong Safe and Supported Framework**. Provincial standards and

consistency are not priorities for a fair number of the stakeholders that we interviewed. One MCFD manager stated, “*Government direction is away from collective, standardized service provision, [towards] regional differentiation.*” In some regions, this approach resulted in significantly more consultation, also including greater voice for front-line MCFD staff. As always, though, even positive changes lead to further challenges. In this instance, we are unclear how the community direction will be linked to equitable distribution of evidence-based practice and to accountability measures. As this approach continues, performance agreements, monitoring systems and evaluation will become even more important.

**Cultural views related to service delivery are critical.** One Aboriginal service provider said, “*If a person is removed from their community for hospital care, neither the client nor the community knows how to manage.*” Several MCFD Aboriginal CYMH staff commented on the lack of a spiritual component in the education material available. Others noted that building trust is fundamental. For instance, the assessment process needs to be more comprehensive, including community history. They described how they do this, cautioning us that it is time-consuming, which is not always understood by supervisors. However, once a worker has earned the trust of one or two families, others are more willing to seek support. As one service provider said, “*We need flexibility to honour our way of doing things, without always explaining to people who don’t understand our process.*”

Continuing with the issue of cultural competence: In many regions, hiring into Plan-funded positions has been difficult due to the scarcity of applicants who have the requisite education, experience and skills in

addition to Aboriginal ancestry. In some cases, decisions have been made to “under-implement” by hiring less-qualified staff. This process may be realistic and even necessary, but raises concerns with some stakeholders. Hiring on the assumption that any Aboriginal person is a better service provider than a non-Aboriginal person could compromise service quality. **It will be important to engage community stakeholders and to separate the political discussion from the operational or service capacity issues within individual communities or service areas.** This requires clarifying whether the purpose is affirmative action or to introduce certain skills or other characteristics. If the latter, then clarifying the expected performance would help ensure the objective can be met.

**In the regions, we heard many innovative approaches to these issues.** For example:

- On Vancouver Island, CYMH staff in some sub-regions have developed extensive community consultation processes.
- Staff in the Fraser region adapted FRIENDS to be more culturally relevant after they found that Aboriginal children were not responding well to the standard program. They made the activities more participatory with action games and included a focus on spiritual well-being.
- In the Interior region, staff from the Aboriginal Peoples’ Family Accord use an approach called “Wrap-around in Indian Country”<sup>10</sup> to assist natural supports and professionals to work jointly.
- Community capacity is a critical issue for Aboriginal service delivery. In the North and the Interior regions, readiness

criteria have been developed for contracting with community-based agencies. MCFD staff commented on the importance of relationships, mentoring and capacity building as key success factors for managing this process.

- In the Interior region, a “Community Service Provider Fair” introduced community members and providers, so they could use resources more effectively.

Still much work remains to meet the Plan objective of supporting Aboriginal mental health. One Aboriginal provider who is also a relative of children with mental health problems said, *“When you are in that situation you just want help. You need a balance of professional help and the support that family and community provide.”* Several providers suggested addressing these different but complementary views by **supporting Aboriginal community members to develop preventive activities and capacity building, while MCFD staff focus on treatment concerns like eating disorders and acute crises.** One way to do this would be training local staff, typically Community Health Representatives, to recognize anxiety, depression, and early signs of psychosis or suicide risk. This approach has been found effective in parts of the North region.

Compounding the problem of waiting times, **transportation challenges are significant for both providers and Aboriginal clients in rural and remote areas,** and qualified staff are hard to find everywhere. Budgets for staff and client travel should recognize that transportation is usually essential for access to services. Where feasible, videoconferencing may be a partial solution for some of the needs. We also heard many positive reports about CYMH outreach workers in Aboriginal communities, who

<sup>10</sup> See <http://www.nativeinstitute.org/training.htm>

provide some assessment and treatment services, help with service connections and meet regularly with local providers and community members to build capacity. This **outreach activity needs further development in most regions.** An additional outreach issue is the need for a pool of qualified therapists and other practitioners to respond to crisis situations that periodically develop in Aboriginal communities. This is usually in response to a rash of suicides or mass disclosures of abuse. It can often be difficult to muster the necessary help from either the adult or child and youth mental health groups. Community-based peer networks like the Inter-Tribal Health Authority ASCIRT program may be useful in this regard.

**Community based programs, especially for prevention of CYMH issues, are difficult to evaluate.** In focus group

sessions, we discussed with Aboriginal and community providers how to evaluate approaches that are not evidence-based. Some Aboriginal providers reacted negatively, stating that they felt they were being judged. To address these concerns, one community-based Aboriginal service manager suggested this approach: *“MCFD took a risk with programs that are promising practice, but not evidence based. We want to show that this can work. We need your help.”* MCFD Regional Aboriginal Service Managers also requested support in the form of performance indicators, outcome measures and evaluation mechanisms to assist them in reporting on CYMH Plan accomplishments. Acknowledging that innovations may require some grace period to mature, we share the view that it would be useful to **support research and data capture for these activities.**

## Recommendations related to building community capacity

1. To support continued community capacity building related to CYMH issues, there should be **a philosophic shift, prioritizing development of collaborative relationships with other service providers**. Independent agencies such as schools and health authorities should be seen as partners who share responsibility with MCFD for delivering specific services to children. When any member of the partnership fails in its responsibilities, the other partners experience problems. Therefore, the development of regional service plans with relevant partners should be mandatory for all government agencies, not voluntary.

This principle of collaboration around CYMH issues should be **jointly agreed at every level of all related government ministries**, from Ministers to line managers. Once agreed at the most senior levels of government, leaders should make a clear statement to ensure the message reaches all relevant staff.

We recommend the following to support consistent collaboration at local, regional and provincial levels:

- a. The Minister's **External Advisory Committee on CYMH** should be renewed with regular meetings. This is an important venue for public accountability. The focus should be on service feedback and emerging priorities, not policy. It should report independently to the Minister, with secretariat support from MCFD staff.
- b. **Reinvigorate the CYMH Network Committee**. This should be developed as a "locus" or forum to harness the creative expertise and energy of diverse internal and external interests. This could be the venue where MCFD's partners keep each other accountable for cross-government progress. In order to keep partners engaged, we recommend
  - Include senior MCFD (both policy and operations), MEd, MoHS/MHLS and Health Authority staff to **exchange information at a strategic level**;
  - Provide the Network with resources so that it can assign tasks and **achieve more than information-sharing**;
  - Use well-designed and appropriately **resourced task groups** so that the main table stays focused on strategy-level issues, and
  - Ensure that information shared at the central table is **communicated effectively** with the larger stakeholder group. Not everyone need attend if they can find out about proceedings in other ways.
- c. **Assign jointly to Regional CYMH Managers/Consultants and Directors of Integrated Practice the responsibility to work with CYMH Team Leaders to engage partners** outside MCFD in addressing CYMH issues at a strategic level. Among other tasks, this should include developing **regional working groups to support CYMH initiatives**. These would help build stronger relationships among all child-serving agencies in each community. This may include such things as:



- Discussing the recommendations of this report to consider whether they have any validity locally and if affirmative, what might be done about them;
- Organizing accredited training for staff from various agencies;
- Ensuring that front-line staff build time into their schedules for collaborative projects;
- Developing protocols or memoranda of understanding that clarify goals, roles and responsibilities of collaborating partners;
- Holding local forums to develop inventories of services and contact lists showing responsibility areas and after-hours access. (where possible similar programs should have similar names to facilitate recognition and access);
- Creating opportunities for staff from different agencies to meet one another (especially new members), and to share success stories and “better practices”;
- Working provincially and locally to clarify procedures to simplify the appropriate sharing of confidential information;
- Sharing accreditation activities such as preparation, self-review and follow-up (accreditation of community service agencies was referred as a model);
- Developing better approaches for data-sharing for planning and monitoring;
- Meeting regularly to share feedback about related programs and inter-agency impacts.

2. **Other structures and processes may also be required to support particular initiatives**, for instance:

- Approaches to support **training in early identification and collaborative management of mental health issues for CYMH partners** such as schoolteachers, crisis responders such as RCMP officers and firefighters, and MCFD staff in other program areas such as Child Welfare should be explored.
- Continued **collaborative planning with Aboriginal community stakeholders**, following the lead in each community to develop services that build on community strengths and are culturally relevant,
- When promising practices are implemented, **develop performance indicators, outcome measures and evaluation mechanisms** to inform ongoing service delivery.
- There should be a **commitment to embed client and family perspectives and resources** into the infrastructure both regionally and provincially. This warrants a formal policy on development and expectations of family advisory committees at the regional and sub-regional level.
- Best practices in **supporting effective parent resource groups** should be explored.
- **Attendance of MCFD staff in school settings** requires discussion at a provincial level to develop clear guidance for local collaboration.
- **Consider increased involvement of parent advocates in parent support and education.**
- A significant MCFD presence is required to **work with MoHS and MHLS in detailing the proposed Ten Year Mental Health and Substance Use Plan.**

- A cross-Ministry task group should be mandated and resourced to provide **clear guidelines regarding sharing of client information**, following direction from the Provincial Privacy Commissioner. Work in Alberta on this topic may be helpful (Alberta 2007). This may also facilitate development of outcome tracking as recommended below.
- Some portion of **any new CYMH resources should be “ring-fenced” in a strategic incentive fund for collaborative projects**. This would mean that they could only be accessed based on proposals jointly developed by MCFD staff working in partnership with at least two other partners (e.g. school districts, youth justice programs, United Way, community agencies, RCMP). This approach also requires clear criteria for acceptance, an ability to monitor implementation and some feedback about outputs for accountability back to the host ministries.

3. We did not explore in depth the issues related to **concurrent disorders** among children and youth. This is a complex area and **requires involvement of senior staff from several Ministries to address the challenges**.

We recommend the following approach:

- a cross-Ministry ADM committee on child and youth addictions (alternatively the CYMH Network could assist in brokering resolution of key issues);
- joint development of common program objectives and priorities;
- tied inter-ministry funding for programs as well as projects;
- common and regular reporting out on activities, spending and priorities.



## Chapter Four

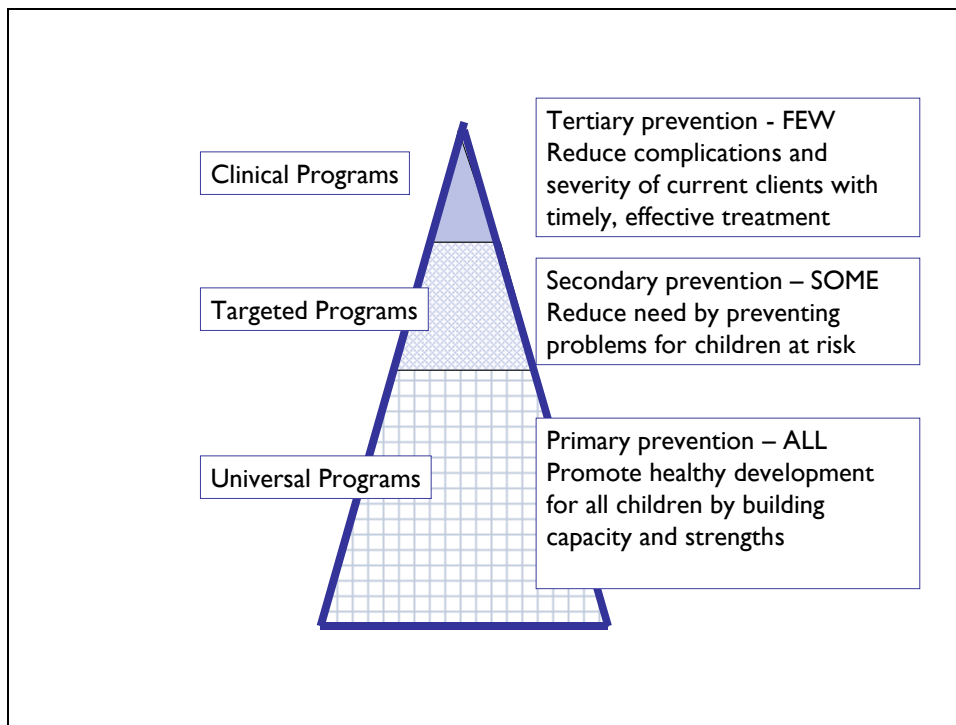
### IMPROVING TREATMENT AND SUPPORT

Ensuring that children and their families have access to a continuum of timely, evidence-based, effective mental health assessment and treatment services is a key strategy. This strategy addresses gaps in the basic range and level of services in each region. It aims to ensure equity of access and to promote the delivery of high quality clinical services.

**Provide a basic level and range of core services in every region.**

Stakeholders support the Plan’s approach with its mix of universal, targeted and clinical programs (Figure 4-1). In the survey of Team Leaders 87% said that a basic range, and level, of core mental health services in their region was “better” or “much better”. Virtually everyone applauded the holistic life-course approach; with several noting the challenges of traveling ever further upstream to prevent distress later in life. As discussed above, it would be helpful to define the basic universal programs available in every region (whether from MCFD, MEd, MoHS and MHLS) to address the present variety and inconsistency.

**FIGURE 4-1 CORE SERVICES APPLIED TO COMMUNITY NEEDS**



Despite universally high praise for the new staff and resources announced in the Plan, there were also concerns. Notably, actual numbers of new hires, their qualifications, job descriptions and activities are not publicly available. To some this absence of data was puzzling; to others frustrating or cause for suspicion. Within MCFD, these data are available and are shown in Figure 4-2. **We recommend sharing widely the information about the new resources as part of a continuing accountability and communication process** (discussed further below).

**FIGURE 4-2 STAFF HIRED WITH PLAN FUNDING, BY MCFD REGION 2005-2008**

REGION	Clinical Generalist	Clinical Specialist	Support Worker	Aboriginal Programs	Unspecified	REGIONAL TOTAL
FRASER	27.48	38.82	4.86	18	-	89.16
INTERIOR	42.75	16.5	10	7	-	76.25
NORTH	16.25	-	7.5	25	9	57.75
VAN.COASTAL	12.5	14.5	2.5	2	-	31.5
VAN.ISLAND	16.46	3.5	1.5	18.8	-	40.26
<b>PROVINCIAL TOTALS</b>	<b>115.44</b>	<b>73.32</b>	<b>26.36</b>	<b>70.8</b>	<b>9</b>	<b>294.92</b>

However, as expected we also heard from most community stakeholders (HA, agency and school staff and families) about **on-going concerns regarding access for children in crisis**. They applaud early intervention and value the support from “high-end” programs such as the Maples and regional Adolescent Psychiatry Units in hospitals. However, they also note long wait-times for “kids in the middle” – those not posing immediate harm to themselves or others but severely distressed. Some children deteriorate to the point of needing hospitalization before they access services. This is not the only example however, and we heard from all regions that kids who are moderately disturbed may “fall through the cracks” until they reach a critical level.

One of the key issues affecting this problem is **the lack of hospital beds and community residential programs in many communities**. (This need was always stated in the context of using hospitalization as the last resort.) During development of the Plan, there was agreement to assign a portion of CF&CS residential services for CYMH. This did not materialize. The result, as we heard in some communities, is that existing facilities house inappropriate age ranges of children and youth. The survey of MCFD Team Leaders reinforced the stakeholder comments with only 8% reporting any improvement in the continuum of residential services; the remainder think the situation unchanged (58%) or worse (34%). We heard from some HA stakeholders that they have begun planning to assess need and capacity requirements to develop their own community-based residential programs. They expressed hope that MCFD staff will work with them in the planning, resourcing and leadership, since this service should be the MCFD mandate. Some community agencies indicated a willingness to collaborate in delivering these services.

Regarding **wait times**<sup>11</sup> for service, no objective data or benchmarks are available. Since no data exist for wait times before 2003, we cannot compare effects of the Plan. Indeed, there may be some increased demand due to visibility of the program and, of course, the well-recognized resource gap. Certainly, we heard reports of significant community need. In one Northern school district for instance, staff reported two-year waiting lists for complex behavioral assessments; in one of their schools, only 15 out of 105 children were considered not to be at risk, while 45% of five-year olds were found not developmentally ready for kindergarten.

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### A SIGNIFICANT GAP BETWEEN RESOURCES AND NEEDS

Although we did not research the literature exhaustively, many researchers agree with the prevalence estimates for diagnosable CYMH issues originally identified in the 2003 Plan (viz. about 15% of all children). Serious functional impairment most likely affects one in ten children (US Surgeon General 2008). Taking the more conservative estimate means that in BC more than 97,000 children and youth experience mental disorders causing significant distress and impairing their functioning at home, at school, with peers, or in the community. Plan resources increased the number of children receiving service from MCFD staff from an estimated baseline of about eleven thousand per year to about twenty thousand (no firm data available). Although GPs, psychiatrists, psychologists, school district staff and community counselors also provide services to some children with mental health problems, no data are readily available about the amount or nature of these services. We think it safe to assume that **the gap between resources and needs remains large** (Figure 4-3).

**FIGURE 4-3      PREVALENCE AND SERVICE ESTIMATES**

Year	2003	2008
BC Pop <19	989,192	973,429
Impact at 1 in 7	138,487	136,280
Impact at 1 in 10	98,919	97,343
Served by MCFD	11,000	20,000
% served if 1 in 7	7.9%	14.7%
% served if 1 in 10	11.1%	20.5%
Gap at 1 in 10	87,919	77,343

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<sup>11</sup> We refer to “wait times” not waiting lists because this is more client-centred. Most families do not care how many people are on a list, although this may be the concern of providers. Families care about how long their relative has to wait.

Subjectively, the **feedback about wait times was generally negative**: In our survey, 57% of MCFD Team Leaders report that the gap between services and need had improved; the other 43% feel that the gap was unchanged or worse. However, over 90% of the front-line staff we surveyed think that service capacity is inadequate given the current demand for services. Many MCFD staff in our focus groups also feel the demand for services continues to outpace capacity. This was attributed to insufficient resources, increased community awareness resulting in higher referral volumes, demographics in particular communities, and a broadened mandate to see children with diverse mental disorders.

Specialized providers such as **physicians and residential services managers usually did not report any significant improvement in waiting times**. Some clinicians expected this and thought wait times manageable; others described “*abysmal*” waits. On the other hand, some community providers thought there had been some improvement. (Although some also noted that they could provide more assistance in managing waiting times if MCFD staff were more collaborative.)

In our focus groups, **almost all parents spoke of very long waits**, often noting that they only received service after their child had deteriorated significantly from first referral. Most of the parents surveyed reported problems with access to services (55% dissatisfied), although the survey and interviews may not represent all parents. A few families reported that wait times were acceptable. We also heard that inconsistent delivery across agencies was confusing for those referring as well as for families. It was proposed that **MCFD should lead local initiatives to ensure consistent “pathways” of care**. The word “seamless” came up often.

**Summing up, waiting times are problematic for most people, most of the time**. We acknowledge that this has been a major concern for CYMH teams in every region for many years and a major focus for improvement efforts. **We recommend that tackling waiting times should be a major focus of regional operating plans** (Figure 4-4). Wait times are measurable, understandable and meaningful to families. By focusing on this area, particularly by using proven process improvement methods, many other issues would be identified for systematic attention. In Appendix 12, we list a number of processes that affect client experience and provider effectiveness. These would be suitable start points for the process improvement journey.

Many people suggested **ways to improve access**:

- **Develop a range of service options** to avoid unnecessary hospitalization. When young people in crisis go to Emergency Departments, the default is hospitalization. Sometimes, alternatives such as focused parent groups, day programs, family supports, could be used.
- **Respite beds are a matter of significant concern for parents**. Many mentioned that access to respite should be based on the needs of the child and other family members, not only protection concerns, as at present. One mother with a multiply-challenged teenage daughter stated, “Unless I call and say she is at risk, there’s no help.” Stating the child is at risk, of course, raises the risk of removal.
- **Use the right provider at the right time with the right type of service**. Psychiatrists commented on the regional variation in the way that their services are used. One commented that

there is too much reliance on highly qualified psychiatrists and psychologists; it would be better to rely more on non-specialist staff such as counselors, and especially, outreach workers, particularly for Aboriginal communities. Parents suggested that younger staff are often most effective with teenagers due to similarities of age and interests. Granted training and clinical supervision are required for these staff and turnover is a problem, but they can be deployed less expensively and more flexibly. Currently most of these positions are controlled by CF&CS; additional positions should be dedicated to CYMH services.

- Others suggested that **earlier intervention and effective management of wait lists** would not only have better results but would ultimately reduce wait times overall. They suggest that early intervention programs should focus on working down the waiting lists. One MCFD office offers Saturday clinics to support families while they wait for specialized assessments. One Northern school district has dedicated a staff member to initial screening in schools with selected cases referred to MCFD for further assessment.
- **More effective linkages to remote communities** including mobile clinics (e.g. for assessments) and better use of video-conferencing. Local providers (often less-qualified than visiting staff) can arrange for traveling clinics, complete pre-assessment reports and offer immediate support.
- **After-hours access**, ideally with “one-stop” access for various services.
- **“Navigator” positions to assist parents** access community agency, MoHS, MCFD and MEd services. These individuals can advocate for families as necessary. Parents should not need to know “insiders” to help them access appropriate resources.

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## SOME GROUPS ARE AT GREATER RISK FROM EXTENDED WAITS

With reference to **priority populations**, there was unsurprising agreement:

- Children in care;
- Families where parents suffer mental health or addictions problems;
- Aboriginal families;
- Children and youth with concurrent substance misuse problems;
- Children and youth who are dually diagnosed with developmental challenges as well as mental illness, or more broadly Complex Developmental Behavioural Disorders.

We also heard several recurring themes **regarding priority conditions that** are not well served:

- Complex multiple problems, such as concurrent disorders, usually associated with extreme behaviours (discussed below with the relevant CYMH Plan reference);
- Attention Deficit Hyperactivity Disorder, with its high risk for serious co-morbidities (we were told that some agencies exclude this condition);
- Eating disorders;

- Services for children who have been sexually abused<sup>12</sup>;
- Services for Gay, Lesbian, Bisexual and Trans-gendered youth;
- Services for younger children often 9-13 year olds, presenting with extreme behaviour problems;
- Programs for youth who self-harm (youth recommendation), and
- Services for high-risk youth, typically those not in school or transient.

A major concern from child and youth clinicians (whether MCFD or agency staff) is that the continuing wait-list pressures and limited capacity have led to an emphasis on ‘Brief Intervention’ approaches or other **time-limited services that may not address the underlying chronicity** of some children’s mental health problems (e.g. severely traumatized children may require support lasting over a year). While they may recognize the appropriateness of phasing out the “standard one-hour-weekly-visit” service model, clinicians remain deeply concerned that they are not able to provide the on-going attention some children and families require. This topic deserves further discussion at the team level. One of the benefits of the evidence-based approach is better matching the intensity of interventions with the client’s level of need and functioning.

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**FIGURE 4-4 TACKLING WAITING TIMES SHOULD BE A PRIORITY FOR REGIONAL OPERATING PLANS**

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According to the Canadian Institute for Health Research Team in Access to Children's Mental Health Services (2008) long waiting periods *disrupt* “the continuity between ... the intake process and the beginning of treatment. The lack of continuity ... may increase problem severity, disrupt the relationship between families and service organizations, and lower the readiness for change evident when families first contact providers. Waiting lists discourage all but the most persevering families.”

Waiting list management is a topic widely covered in the literature. **Regional executives need to be better informed about this issue and should make improvement of wait times a strategic priority.** In particular, we recommend:

- **Effective and consistent triage processes are important.** Application of the BCFPI triage criteria should be strengthened and standardized across regions. Parents understand that other needs may take priority: “*When you are a parent in crisis, it is important to know that priority will be made.*” Severity of need should guide prioritization. However, there must also be some recognition that low-priority problems may always be displaced by higher needs. Alternate programs should be developed, rather than no-end waits.
- **Centralized intake** can reduce the inefficiency of multiple entry points to services. However, central intake should be monitored to ensure that new barriers

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<sup>12</sup> The Ministry has initiated a number of new strategies to **improve services for children and youth who have experienced sexual abuse** and their families. These strategies include: evidence-based training in Trauma-focused Cognitive Behavioural Therapy for Sexual Abuse Intervention Program (SAIP) providers and CYMH clinicians in 2007; development of new SAIP Standards to improve access and quality of services in 2008; and an annualized increase of \$1.5M in SAIP funding beginning in 2008.

are not created. In particular, the practice of rotating intake duties dilutes expertise and may lead to variability in practice.

- Waiting lists need **active management**, with designated staff contacting families to advise them of wait times, offering intermediate support, checking whether the child’s functioning has improved or deteriorated and how the family is coping generally, and reprioritizing.
- **Novel approaches are emerging** to address this situation. In some Northwestern BC school districts for instance, social work students are trained in screening and multidisciplinary collaboration, which helps reduce wait times. A national research project supports families during waits by using weekly telephone calls from a trained “coach”, a handbook of exercises, and videotapes demonstrating effective parenting strategies (McGrath 2008). This type of **experimentation should be encouraged, incentivized, monitored** as part of regional operating plans. A provincial think tank on this topic could identify best practices and “beacon sites”.
- Intermediate **support from parent resource groups** or other sources can enhance the child’s strengths as well as the capacity of the family to manage the child’s behaviour.
- Instead of relying on anecdotes, “**service maps**” can help track how families are actually accessing the CYMH system. The map may show “dead ends” when a professional does not refer, so the parent needs to find another way to a specialty centre; “gaps” where a service does not exist; and “duplication”, where the child receives multiple assessments by many professionals, which may contribute to waiting lists and unequal distribution of services.
- **Waiting times should be measured, monitored and publicly reported** so that over time, baselines can be established and target times for waiting developed, ultimately to guide resource allocation. There should also be regular independent audits of waiting lists and their management processes to ensure transparency and adherence to criteria.

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**Finally**, regarding basic services available in each region, we recommend that **each region should develop a plan for after-hours care in every community**. One HA manager reported that in their major communities about 25% of all after-hours care provided by HA teams is for children and youth. Such an after-hours plan should be documented and available to all providers. It might include for example a flow sheet about service providers, their roles and specialties, their hours of availability, how to contact them, and who to contact after regular office hours. At a minimum, the

provincial After Hours office, which responds to Help Line calls from around the Province, should be staffed with a qualified CYMH practitioner who can support local staff in after hours interventions.

**Work in partnership with other service sectors to address the mental health needs of children with complex multiple problems such as mental handicaps and mental disorder or addiction problems and mental disorder.**

In addition to the clinical priorities discussed above, those we surveyed were consistent



about the most vulnerable populations, also noted below. Unless mental health problems are also present, CYMH services do not include services to children suffering neuro-sensory deficits, FASD, autism or substance misuse. Moreover, some providers do not consider behavioural problems within their mandate, even though these may arise from various causes. Several people thought that **distinctions in the way MCFD organizes services are unhelpful**. A school-based MCFD clinician commented that many children in his practice are best described as experiencing the effects of “complex psychological trauma” (Paletta 2008). Another recommended that we should reconceptualize client needs to recognize multiple difficulties across multiple domains where systemic disorganization overwhelms the individual. A third recommended that MCFD staff need to change their orientation to triaging children for assessment.

*“Managers should mandate acceptance of behaviour difficulties [for follow-up] whether the cause is a DSM diagnosis...or any other problem in the mental health realm. It is not acceptable to screen out children based on perceptions.”*

We support this view and recommend that regional staff (CYMH Leads and Directors of Integrated Practice) should consider ways to reduce fragmentation of service streams and resources.

Needless to say, **special populations do not fit neatly** into a model that defines and limits timelines for service based on simpler situations. *“The diagnostic streams are not working together,”* one community agency director reported. Another commented that multiple problems often force parents to work with multiple agencies to receive services. We heard many stories from parents about children and youth with very high needs who are not effectively served by

medical, community or school-based programs. MCFD managers are acutely aware of this problem. Several spoke of “wrap-around” approaches involving central coordination of various resources. However, they also lamented the poor connections with HA resources and overall limited capacity that typically confound their efforts.

**Services for children who have a combination of mental health and cognitive challenges (“dual diagnosis”) require specialized approaches.** This was highlighted as a priority group because, although a small population, it is expensive and difficult to serve. MCFD staff reported that Dual Diagnosis training was delivered March 2008 with more training planned for early 2009. Plans to provide group clinical consultation to dual diagnosis clinicians through videoconference are also being coordinated by the provincial CYMH team in consultation with the regions.

**Children in Care also require a more dedicated and specialized focus.** The long term outcomes for this population – poor educational performance, unemployment, mental health problems – highlight the importance of appropriate service provision. Approximately 30% of CYMH clients are Children in Care. This is an important population needing significant improvement in service coordination. We also heard that children in care who have mental health problems sometimes receive inappropriate support services and residential services that do not adequately meet their particular needs. Closer working of CF&CS with CYMH staff could result in development of a more effective range of support services with more appropriate and cost-effective use of resources.

**Concurrent disorders (youth suffering both mental health issues and addictions)**



**are a major concern for many providers and community members.** On the adult side, MoHS is responsible for both mental health and addictions; MoHS is also responsible for youth addiction services. In best practice systems, CYMH and addiction services are closely linked, recognizing that many people with substance misuse problems have mental health issues. However for youth in BC, mental health and addictions issues are usually served separately. Their addiction problems are treated as an adult issue, but with less attention because of the smaller affected population. Sometimes this leads to inappropriate pooling of age groups (e.g. groupings include 16-24 year olds or 14-20 year olds struggling with addiction.) We were advised that from a clinical perspective, youth should be dealt with together, and concurrent clinical disorders should be dealt with together.

**The children of parents who suffer mental illness were noted as being vulnerable although they may not meet criteria for service in early childhood.** Several people suggested partnerships with Adult Mental Health and Addiction Services to develop special programs aimed at helping these children.

As discussed above, another vulnerable group is **children and youth living in Aboriginal communities, especially where community mental health is impaired.**

**Partnership working is a topic cited by many providers and community members.** One of the biggest problems reported by advocacy organizations is “hit and miss” coordination of services. This applies not only to the most complex multiple problems referenced in the Plan. One provider commented that **many mental health conditions affecting children and youth involve multiple systems.** We heard

of successful examples of interdisciplinary team working but these tend to be isolated, possibly due to our survey method. There is a perception that successful coordination across service sectors is dependent on individuals rather than systems. This is discussed further below, and we provide in Appendices 9 and 10 further guidance to assist teams from various service agencies in planning a coordinated approach to service delivery.

**Improve collaboration with general practitioners and family physicians.**

#### **Why is this objective so important?**

Frequently family physicians or General Practitioners [GPs] are the first point of contact for families with a child experiencing any kind of physical, emotional, mental or behavioural disturbance. (Over 86% of parents responding to our survey reported that they had initially accessed their family doctor for assistance with their child’s problems.) In some cases, the GP remains the primary support for extended periods. It is important also to note the contributions of pediatricians and child psychiatrists. One specialist estimated that children and youth with behavioural and developmental problems make up 40-60% of the clients seen by pediatricians. Many stakeholders commented on the importance of these relationships, with one stating, **“CYMH is a health service linked to a continuum of health services in a very different way than child welfare services.”**

Therefore, **the Plan’s emphasis on improving collaboration with physicians seems sensible.** Physicians have been included through participation in Expert Tables as part of the CYMH Plan, their contributions to training initiatives, and

through participation in training opportunities themselves. MCFD staff note that more could be done to engage effectively with physicians. There is also scientific evidence showing benefit from providing better support for GPs. Katon et al. (2003) highlight two studies where psychiatrist and psychologist collaboration with GPs resulted in both improvement in depression and enhanced cost-effectiveness compared with usual care.

About one-third of the MCFD Team Leaders we surveyed reported **improvement with involvement of primary care**; over half saw this as unchanged however. Unfortunately, we also heard from stakeholders of many problems related to greater involvement of GPs in delivering CYMH care to children and youth.

- Medical education in CYMH issues is sparse for medical students and even for pediatricians.
- Most medical doctors work largely in their private offices with occasional time spent in Health Authority premises such as hospitals and nursing homes. Their interactions with MCFD staff are sparse and often relationship-based.

- The use of drop-in clinics compounds the problems, as there may not be consistent primary care for kids in need.
- One specialist confided to us that some GPs “flounder” when dealing with children who have early symptoms; they refer to many resources, which may confuse the situation as well as adding needless strain for parents. Thus, complex clients, multiple jurisdictions, professional “silos” and complicated relationships result in service gaps.
- Primary care models are not well defined across BC. For instance, the recent Perinatal Depression Strategy required a major investment of resources to develop its comprehensive approach.

From the medical perspective, MCFD services are seen as community specific, with practices varying even within sub-regions. This variation creates difficulties for physicians in referring their patients to MCFD services as structures differ in each community. Although this problem pre-dates the Plan and recent regional re-organization, such **variability makes it difficult for physicians to work with teams.**

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## SYSTEM CHANGES WILL BE REQUIRED TO IMPROVE INVOLVEMENT OF PHYSICIANS

A recent survey of physicians in Northern BC found that many are very interested in improving CYMH services (Berland 2007). Despite the local variations, given the right leadership, international experience suggests **opportunities for new ways of working** (e.g. Glasgow, Orleans, Wagner 2001; Center for Effective Collaboration and Practice 2008). Some of the medical specialists we interviewed for this report

described their experiences with effective teams. Typical characteristics of effective teamwork include co-location with CF&CS social workers albeit with separate access for fragile clients, shared assessment processes, close involvement of GPs, resources such as Family Support Workers, and regular time for team meetings and education. One community representative proposed that GPs need resources such as

tear-off information sheets, for supplementing patient education in their offices.

Policy relating to all types of GP services rests with the Ministry of Health. Recently MoHS has developed extensive policy and program supports relating to primary care and the management of chronic illness, including mental illness (British Columbia 2008b). A Guidelines and Protocols Advisory Committee oversees practice guideline development, co-chaired by the BC Medical Association and the government payer, BC Medical Services Plan. Within this broader framework, clinician-led working groups have developed guidelines for various conditions, including conditions like diabetes and depression in adults (British Columbia 2008c). Recently one working group has been working on a **clinical practice guideline entitled, “Anxiety and Depression in Children and Youth - Diagnosis and Management.”** The first public draft will be released in September for consultation.

Use of this guideline will be voluntary for GPs. There are no rewards or sanctions for adhering to evidence-based, peer-reviewed practice. However, a new **“Mental Health fee”** has been added to the payments available for GPs. This includes compensation for time spent in planning care for child and youth clients. According to the Medical Services Plan website,

*“Family Physicians provide the majority of mental care [sic] in BC. This is time consuming and is often not adequately compensated, so the Mental Health fees have been created...the eligible patient population is restricted to patients living in the community (their own homes or assisted living) who:*

- *Have an Axis I diagnosis confirmed by DSM IV criteria,*
- *Have Severity and Acuity level causing sufficient interference in activities of daily living that developing a management plan would be appropriate.”*

According to the few doctors we spoke with, **communication with MCFD staff has improved since implementation of the CYMH Plan.** However, even this is not consistent across all regions. We heard of community-level meetings held weekly in one community for centralized intake, triage and consultation. These meetings include MCFD clinicians, a pediatrician and a child psychiatrist. In addition, the team provides educational sessions for GPs, improved its referral processes and surveyed clinicians for feedback about their service. Unfortunately, this appears to be funded through an anomaly and is certainly not a widespread model. Moreover, even when the sessional fees are available, they are not high enough to attract private practitioners. This area deserves further analysis and cross-Ministry problem solving.

We heard frequently about the shortage of child psychiatrists, particularly of those willing to travel to non-metropolitan areas. We recommend that MCFD contribute to the provincial oversight of this issue and to **recruitment initiatives** by Health Authorities.

Overall, we noted a **philosophical gap between those trained in social sciences and those trained in medicine.** We heard several pejorative comments from both sides, which are well known and not worth repeating here. This is a serious concern especially for early assessment and intervention with younger children. We recommend every opportunity to address these issues through expert working groups

and “Better Practice” approaches based on evidence as well as community responsiveness. Educational approaches are likely to have a positive reception. In the first instance, it would be helpful to work with organizations such as BC Medical Association and the College of Family Physicians of BC to discuss approaches, particularly for education about CYMH issues within the MoHS-BCMA Practice Support Program.

**Improve the coordination of transitions from the child to the adult mental health system, and between community and hospital.**

Despite a decade or more of discussion about youth transitioning from MCFD to MoHS programs, “cross-ministry impediments” remain a significant concern for many people. Nearly 80% of the Team Leaders surveyed thought this problem unchanged or worse since 2003. This was also one of the most common specific problems documented by parents. These are the main concerns:

- Clinicians expressed concern about the differences in services offered, where the adult mental health system treats few conditions except schizophrenia, depression and bipolar disorder. Many youth on the other hand are functionally impaired due to different underlying causes. Several providers specifically referred to exclusion of ADHD and conduct disorders from adult services.
- Clinicians and parents both commented that the legal age of majority is arbitrary: transitional planning should recognize that young people might not mature neurologically until their mid-twenties. We heard often about families dreading the risks of transition even though their own children are still quite young.
- There also needs to be anticipation by

MCFD staff to prevent crises that may occur when a youth experiences growth spurts. At these times, mental illness can suddenly present more violently and the youth may be too large for a parent or teacher to restrain. Tardy responses create risk.

- Families report that when they move from one town to another, files may not be transferred and so their children need to be reassessed before receiving supports. Communication barriers between MCFD, medical and school district staff compound an already stressful experience.

Complex processes create barriers for clients who need services, especially if their parents are not able to be strong advocates for them.

**This topic requires leadership involvement as well as expert management.** It may be appropriate to define much longer transitional time periods where planning and follow-up are closely linked between MCFD and HA services.

**Even within the younger age groups, transition problems arise.** One parent described the gap in planning between BC Children’s Hospital and local CYMH teams: *“We fell through the cracks.”* Another break point occurs between services in the early childhood years and the elementary school system. One parent said, *“When our son went from the ECD world to the K-12 world, it was like we fell off a cliff. It took a lot of self-advocating, making phone call after phone call after phone call.”*

**The parents who responded to our survey were generally dissatisfied with the communication and coordination between different service providers across the broad system of services** (viz. GPs, MCFD, HA staff and community agencies). Only 25% said they are satisfied or very satisfied; a considerable proportion of parents (25%) were uncertain about this aspect and half (50%) are dissatisfied or very dissatisfied.

These sentiments were further reflected in their **ability to obtain important information** (such as diagnosis, treatment, care planning, implications for school) about their relative, where again half of parents surveyed were dissatisfied or very dissatisfied. As one parent stated in a focus group, *“We see the system holistically. We expect child-serving agencies to collaborate, to communicate, and to live up to their stated values of child-centred practice – to connect the dots, regardless of their mandates.”*

**In general, partnerships are widely seen as lacking substance and effect.** This refers to several levels, with parents typically noting the local or client-level effects, front-line staff referring to programs, and managers and policy staff observing cross-Ministry impacts. One community advocate asked, *“How do we get Health, Education and MCFD to hold hands and say this is our issue?”* Specific **priorities for joint working** were further detailed as:

- transitional services for youth aged 15-24;
- linkages between community and acute care services;
- suicide prevention and intervention services;
- concurrent addiction and mental disorders;
- school-based mental health services;
- early identification and intervention for children and youth experiencing or at risk of developing a serious mental illness, and
- improved services for children less than 12 years.

People spoke of the need for **“seamless” transitions and a continuum among all government Ministries** (including private sector physicians) and all age groups. Parents described their vision as an “umbrella system”. A physician

recommended the way that the rheumatology program at BC Children’s Hospital transitions clients between pediatric and adult systems. Stakeholders also noted that youth transitions frequently require some residential support. At present, the only options are youth-oriented Supported Independent Living programs [SIL], which do not address the needs of youth with limited life-skills. They recommended “super-SILs” or other models to provide more support in a natural setting.

As expected **collaboration between Health Authority staff and CYMH staff varies across the province, even within regions.** We heard many examples of excellent collaboration in areas such as youth day treatment, crisis response, eating disorders. In some communities, programs operate jointly: MCFD and HA employees are co-located or work side by side in community settings. Unfortunately, we also heard of situations where the two systems are so strongly polarized that no effective joint working occurs. This is a significant concern for agency staff and advocates in these communities. **Because joint working is critical, we recommend:**

- MCFD Region executives need to link proactively with HA executives to maintain a consistent focus on improvement for CYMH services. Senior leaders from both systems need to discuss the joint problems frankly, establishing clear performance expectations and consequences.
- Each MCFD region should ensure that Regional CYMH Leads and CSMS participate actively in collaborative committees with HA staff.
- Operating plans and managers’ performance expectations in MoHS, MHLS and MCFD should include specific deliverables related to collaborative practice around CYMH.



- A portion of any new funding should be accessible only for initiatives where there is evidence of collaboration with HAs and community agencies.

**Improve equitable access to psychiatric acute care for children and youth – locally, regionally and provincially.**

Some people we spoke with view “psychiatric acute care” as a red flag concept; others see this as an essential component of effective treatment. We raise the issue because a simplistic “pills versus skills” debate appears unhelpful. Most stakeholders reported that they are generally comfortable with the notion of approaches for primary prevention based on individual and family strengths. Some stated that this is consistent with the CYMH traditional approach of building coping skills in their clients. One clinician suggested that services should be developed around a model of assisting clients to re-enter their society, with skills to manage their personal, family and social systems. However, other people reported concerns about not offering diagnostic analysis for children who need intensive or individualized treatment: “*Avoiding labels can be problematic,*” as one senior educator stated. Family members made joking references to the “alphabet-soup” they had learned from diagnostic codes. However,

some also stressed that they got better responses from classroom teachers or MCFD staff if they had a diagnostic “label” from a qualified professional.

Family members and clinicians like the idea of using needs or functionality as the basis for deciding what MCFD support is appropriate. However, clinicians told us that they want **further discussion about how to operationalize the concept of “strength-based approaches”**. Needs-based services or triage criteria are also seen as a fairer way to allocate scarce resources than diagnostically defined programs, which may not take into account the functional status of the child or the family’s coping ability. In order to meet the CYMH Plan goal of equitable access, it will be **necessary to identify and apply appropriate measures of child and family functional status and need**. In combination with appropriate cross-government policies, resource allocation may then be adjusted on an equitable basis.

**Summing up the issue**, all stakeholders appear to recognize the need for a broad bio-psycho-social-spiritual approach that respects family involvement and cultural safety as core values. **Access to treatment and support should be equitably based on functional needs and the family’s ability to address those needs, as well as clinical diagnosis.**

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## **Insufficient residential resources are a significant concern**

Turning to other aspects of psychiatric acute care, there was no budget specifically for MCFD CYMH residential programs as part of the Plan. Not surprisingly, then, we heard **frequent and strong concerns about insufficient access to community**

**residential programs especially for adolescents**. Ninety-two percent of Team Leaders, for instance, felt the system was “unchanged”, “worse”, or “much worse” in providing an appropriate continuum of residential services (Appendix 4). This

refers not only to hospital-based programs, but also to a range of residential services from independent living, to Level Three Foster Parents, to intensively staffed services like the Maples.

Several stakeholders recommended “**step-up**” and “**step-down**” facilities, ideally distributed all over BC. We agree with this recommendation. These residential programs could serve several purposes by offering a higher level of service than available in day programs, in an environment closer to home and less intrusive than a hospital. CF&CS should not control access to such homes as occurs presently. The purpose would be therapeutic, for example, offering a transition to or from hospital, in order to help parents and youth prepare for changes. In some cases, such a facility would also provide a respite function. This model would also improve flow through hospital services, ensuring acute care facilities are used only for those needing this scarce, expensive and potentially traumatizing level of care.

A related topic was the need for “safe houses” where street youth could be provided shelter and some basic services. The example cited was a youth who had not taken anti-psychotic medications for the past week and was forced to leave his home because of partying there. These youth are at greater risk for depression, substance misuse and suicide. Youth services are typically fragmented, so a residential centre could also provide basic medical care, alcohol and drug counselling and mental health services. This might also reduce hospitalization for some of these vulnerable youth.

**Maintain effective interventions supported by research evidence as the standard of practice throughout the service system.**

This foundation element of the Plan appears to be **endorsed by front-line clinicians**. Their responses to our on-line survey (Appendix 5) show their commitment to delivering interventions supported by evidence:

- They routinely involve families and caregivers in treatment/support (98%)
- They routinely coordinate with Child Welfare, school districts, and public health services (97%)
- They employ a strengths-based developmental approach (96%)
- Their clinical practice is aligned with evidence-based practice (95%)

Over 92% of Team Leaders think that service provision has improved with the application of evidence-based practices. The academics and policy officials with whom we spoke were pleased with the use of “Expert Tables” during the early years of the Plan. They felt that this was an effective way to harness the views of diverse professionals and the format encouraged constructive, solution-focused discussions.

Staff in focus groups were also generally pleased with the emphasis on evidence-based practice, but also cautioned that **clinical judgment, “relationship-based effectiveness” and community input are also important program aspects**. Clinicians generally agreed that where they practice innovative approaches, they have an obligation to evaluate such practices. More generally, several people asked how

standards of practice are being evaluated to ensure effectiveness and consistency. This is a special concern in relation to contracted agencies.

**Parents were less satisfied with quality of care received across the broad system of care:** 44% reported being *satisfied* or *very satisfied*. A sizeable minority (18.5%) were uncertain regarding their satisfaction with care quality, while the rest were *dissatisfied* or *very dissatisfied*. However, when asked whether the services had made a **positive difference in their child’s ability to function at home and at school**, the majority reported *some difference* (61%) or a *significant difference* (13.4%). One in every four respondents (25.6%) reported *no difference* (Appendix 3). This inconsistent finding deserves more exploration, preferably through regular family and client satisfaction surveys.

Generally, the emphasis on consistent evidence-based practice shows a promising start. However, it needs **resources and leadership for continuous improvement**. In addition to regional leadership by CYMH staff, there should be provincial leadership to ensure consistency and resources for research, training and evaluation initiatives.

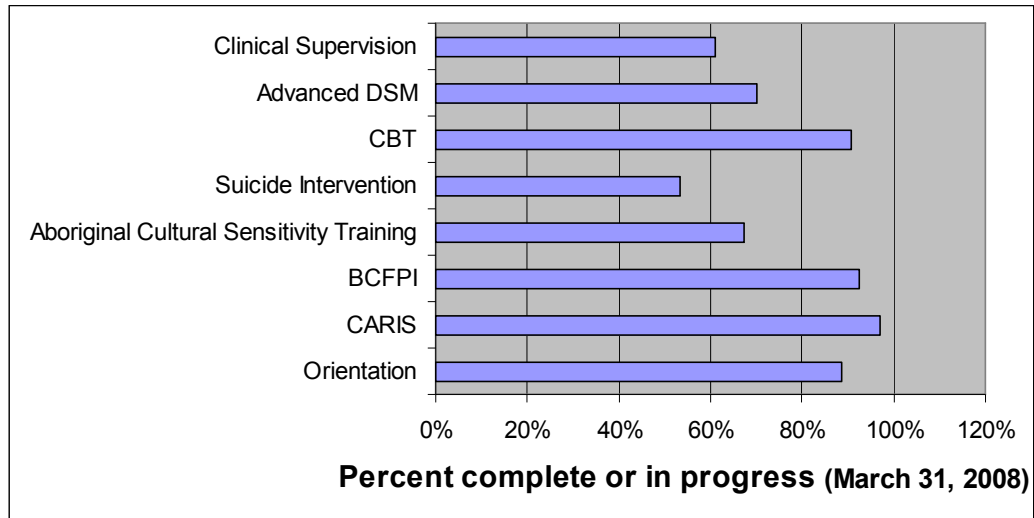
**Review and revise existing standards and competencies to comply with evidence-based practice guidelines for all direct service mental health clinicians and provide ongoing training to maintain the standards.**

With revised clinical competencies linked to evidence-based treatment approaches, the CYMH Plan provided **funding for two levels of core training for MCFD staff**. Firstly, the “Core Level 1 Training” required all CYMH staff to complete these modules:

- Community and Residential Information System [CARIS]
- Cognitive Behaviour Therapy [CBT]
- Aboriginal cultural sensitivity training
- Suicide intervention
- Advanced Diagnostic and Statistical Manual of Mental Disorders [DSM]
- Clinical Supervision – for all clinical supervisors
- Orientation – for all new staff
- Brief Child and Family Phone Interview – for those doing intake [BCFPI]



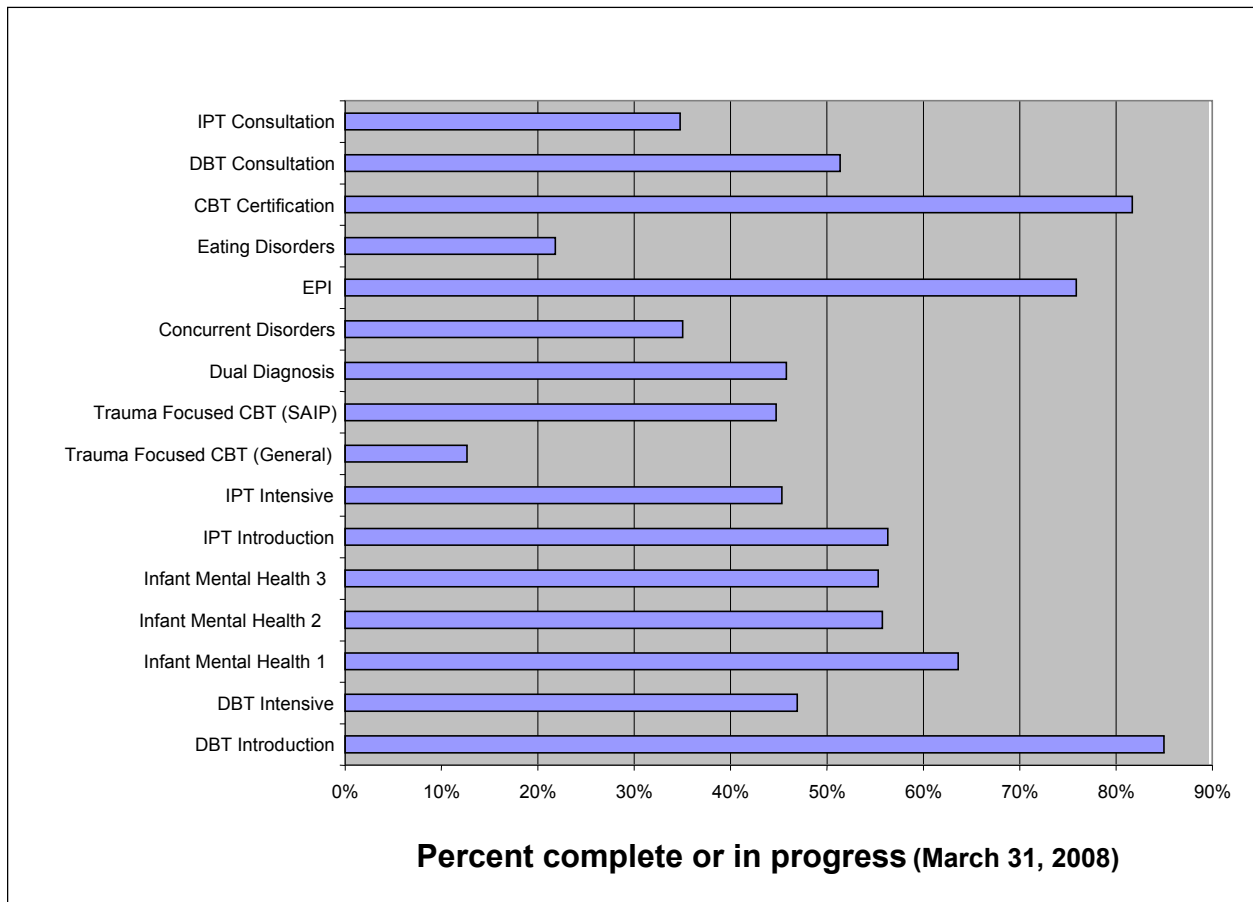
**FIGURE 4-5 MOST MCFD STAFF HAVE COMPLETED LEVEL 1 TRAINING**



Secondly, the “Core Level 2 Training” requires a minimum of one person per team or community to train in each of these specialized areas of practice.

- Dialectical Behaviour Therapy [DBT]
- Interpersonal Therapy [IPT]
- Infant Mental Health
- Dual Diagnosis
- Concurrent Disorders
- Eating Disorders
- Early Psychosis Intervention [EPI]
- Sexual Abuse Intervention [SAIP]

**FIGURE 4-6 TARGETED TRAINING IS REACHING SPECIALIZED STAFF**



**MCFD staff reported that significant efforts and resources for training have continued through 2007/2008.** In 2007 a series of focus groups with regional CYMH Team Leaders (n=53) found that over 80% rated the efforts to promote evidence-based practice as good or excellent (McEwan 2007). As shown in Figure 4-5, most MCFD staff have completed the core training modules (see Appendix 7 for data). Figure 4-6 shows that impressive numbers of staff have also completed the targeted training. In keeping with new standards of practice for Sexual Abuse Intervention Programs (SAIP) developed in 2007, evidence-based training in Trauma-focused Cognitive Behavioural Therapy has been provided to SAIP practitioners and CYMH staff. Given the

challenges of hiring a significant number of new staff and the on-going management of staff turnover, **this program of training is a major accomplishment.**

**The good work around training is continuing.** The CYMH training plan for 2008/09 is being developed in conjunction with Regional CYMH Managers/Consultants and in consultation with MCFD Learning and Development department and the Regional Support Council. An inventory of completed training was compiled in June 2008. This will assist in determining future training priorities. In spring 2008, a two-day Forum on Best Practice in CYMH gave the subject high profile attention.

In addition, post-hire training is currently under development for entry-level staff, when referred by their clinical supervisor because of gaps identified in basic CYMH knowledge, skills, and experience. Education at the BSW level about CYMH is minimal. We heard that some entry-level staff have limited mental health experience when they start. As a result, the staff themselves may share public perceptions about the work that can be far from reality. We also heard concerns that job descriptions need to be connected to evidence-based practice. This issue of **“job-ready graduates” and “graduate-ready jobs” is a fundamental HR issue that requires a strategic approach** involving MCFD HR staff and service managers, higher education institutes, and likely, union officials.

**Many external stakeholders commented very positively on the Plan’s emphasis on training for staff.** They and the MCFD Team Leaders commented that the quarterly newsletter produced for MCFD by the SFU Children’s Health Policy Centre is a consistent resource that they share with their team members. They also emphasized the on-going need for professional development to work with front-line staff, noting that staff turnover means that training must be repeated for new employees.

**A major training theme was integrating evidence and policy with practice. This includes interdisciplinary work and supporting practice in a matrix environment, recognizing the different levels of service delivery with region.** One CSM spoke of the need to *“strengthen the culture of sharing resources”* within MCFD. Regarding areas for on-going staff development, the following specific topics were priorities among those we interviewed:

- Assessment and prevention of suicide risk.

- Early Psychosis Intervention (small but critical population).
- Working with children who have experienced trauma.
- Early Childhood Mental Health (e.g. Parent Child Interaction Therapy; e.g. use of play with non-verbal children).
- How to share confidential information appropriately with other providers.
- Some clinicians feel the training in specific modalities (e.g. CBT) should be balanced with a focus on training in more systemic approaches, such as dealing with whole families.
- How to integrate services across MCFD program streams (e.g. CYMH, CF&CS, Youth Justice).

A special concern was expressed regarding MCFD’s **management of contracted services**. The example provided was hiring of under-qualified staff who do not follow evidence-based approaches. Both community agency managers and MCFD Community Service Managers frequently mentioned the need for training of contracted agency staff. Training programs should be team-based and community-wide to ensure that “better practice” is consistently applied. We note that this has resource requirements and that not all training is suitable for all staff.

**Institute appropriate clinical supervision mechanisms.**

**The CYMH Plan added new clinical supervisor positions in all regions.** All CYMH Clinical Supervisors have undergone clinical supervision training over the last two years in a competency-based model of supervision. This model provides a

framework for initiating, developing, implementing and evaluating the process and outcomes of supervision. It can be applied to different levels of clinical practice and is relevant for all mental health professionals in CYMH, except psychiatrists. The implementation of this model currently includes ongoing consultation with clinical supervisors through videoconferences to reinforce the clinical supervision training and strengthen regional capacity related to supervision practices. Education to support CYMH clinicians to receive clinical supervision has not yet been developed.

In the recent survey, however, almost 70% of front-line staff reported that relevant clinical supervision is available to them. This is a substantial improvement compared to supervision before the Plan. However, we recommend **further emphasis on supervision, given the inherent risks and stresses of the work and the number of new hires.** Clinical supervision is a complex task made more challenging by front-line staff turnover and the added difficulty of recruiting effective supervisors. The recent reorganization of MCFD programs adds to the complexity. One MCFD stakeholder spoke of a “culture shift” and the need for “acclimatizing” as CYMH staff are integrated within regional operations. Added to these everyday challenges, the shift to evidence-based practice means that some staff are expected to change their ways of working significantly. An external stakeholder spoke of the need for a supervision strategy for embedding the practice changes beyond just “training events”.

To further support the implementation of specialized clinical approaches, MCFD staff report that **clinical supervisors will also receive supervision training related to the newly introduced treatment modalities during 2008/2009.** (We also note that BC

Children’s Hospital offers CYMH teleconferencing services. This may be one way to improve clinical supervision with access to expert resources.)

Some regions have changed their management structure to provide clinical expertise locally as well as at the regional level. Nonetheless, one RED pointed out the common struggle to provide clinical supervision for a small, specialized program that is distributed over vast geography. Many, many clinicians and community groups expressed **concern about the level of support available to CYMH clinicians in the MCFD Regions.** *“The informal networks of CYMH clinicians collapsed when staff were pulled back into their integrated community teams,”* as one person described it. Others commented that Community Service Managers [CSM] lack the necessary background and training in CYMH issues to provide effective support to Team Leaders. Some questioned whether CSMs understand the preventive focus; others noted that CSMs’ control of residential facilities sometimes left CYMH clients vulnerable due to under-recognized risk factors. Overall, the CF&CS focus is seen to dominate. One CYMH team leader asked, *“Why do none of the CSM’s come from a CYMH background?”*

**Staff turnover, a concern in many communities,** compounds the challenges of supervision. Building trust is often a prerequisite to collaborative work. Yet, community agencies and school district staff often commented on the difficulty in knowing about changes in CYMH personnel. As we heard from so many stakeholders, the quality of service in a community depends on effective relationships. This concern has no simple solution. Continuity may be aided by creating enduring structures, such as committees or projects that have sufficient foundation to endure despite staff changes.

These foundations might include for example, written policies, both formal meeting times and informal get-togethers, advisory boards of local residents, and explicit policies for handling information transfer when key staff members exit.

**Maximize efficiency and effectiveness by standardizing practices that need to be consistent across the province.**

Although 73% of Team Leaders thought that access to culturally appropriate services had improved, some community respondents commented that parents, particularly those from cultural minority backgrounds might have difficulty knowing how to access the service system. *“Sometimes it is a question of who is available that day.”* It is not clear whether this is an example of “every door is the right door” or an inaccessible system. One parent stated, *“The system is so complex that you need someone to help you navigate. Professional staff don’t always know all the resources.”* (Figures 4-7 and 4-8) Another stated *“It’s like navigating through a fog during a storm.”*

One RED suggested that **the system needs to shift to recognize these navigation problems faced by parents.** The Plan-funded Sooke Navigation Demonstration Project may be a model that other rural communities could apply. In terms of understanding the problem, additional data about wait times for various conditions would be helpful. As with the national strategy to reduce wait times for surgical procedures, this could be addressed with a staged approach based on service access standards for a few conditions and situations.

**Many knowledgeable CYMH service providers suggested that the focus on evidence-based practice must continue to be emphasized.** Some commented on the

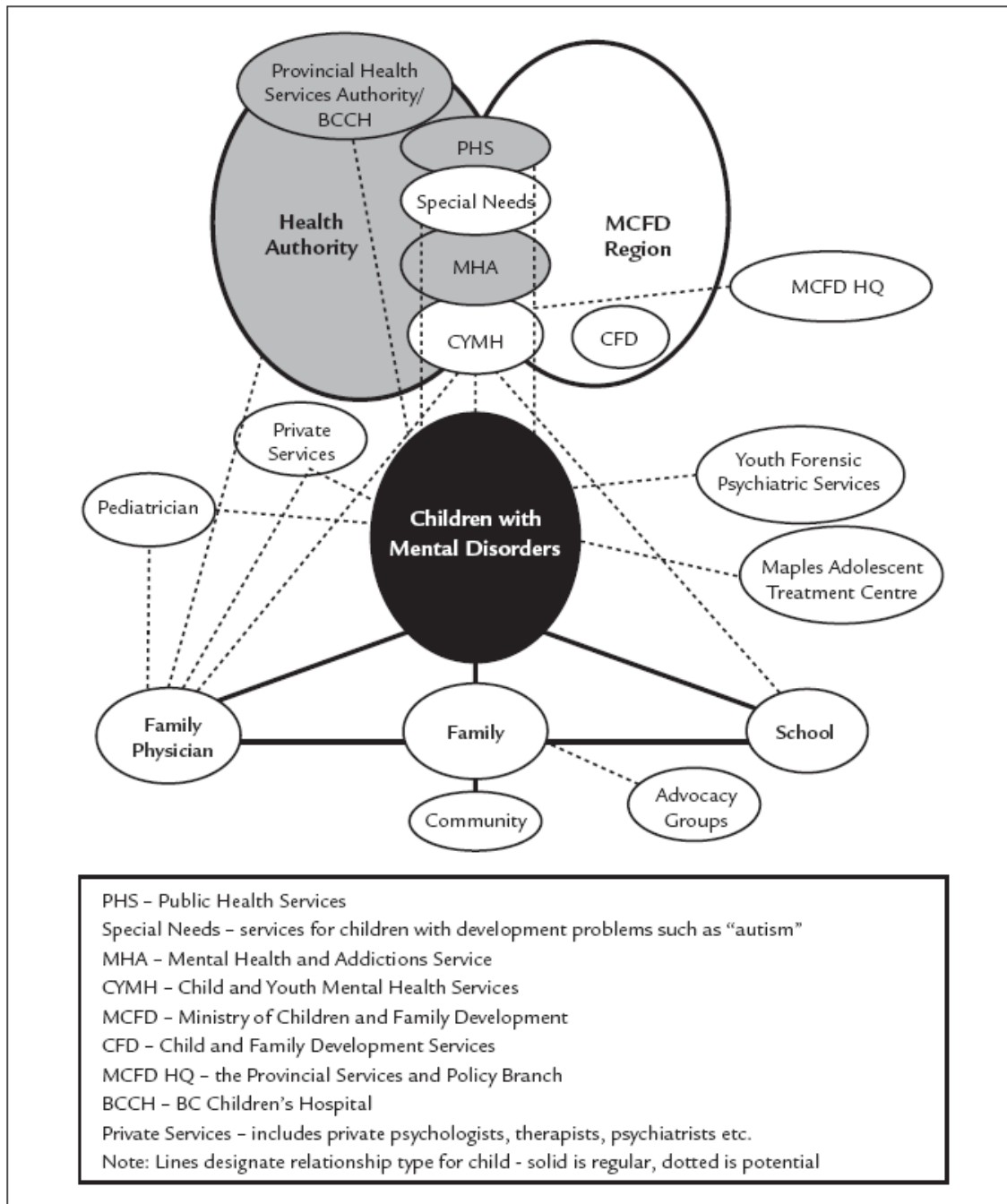
professional resistance to proven approaches from clinicians who prefer primarily counseling, and others who prefer experiential approaches. Some HA staff suggested that certain MCFD clinicians focus too much on their role as therapists. They feel that this limits effectiveness especially when combined with high agency turnover. A client may receive several diagnoses with resulting changes in approach. They recommend instead **a more consistent approach to identifying and addressing strengths and needs, with collaborative service delivery through a team-based model.**

As noted above, physicians were critical of service variation across MCFD sites. A GP stated that, *“Most family docs find the existing system impenetrable and confusing and extremely challenging to access.”* We heard the same concern from specialized service providers. One suggested that senior staff may need to lead the redesign proactively to ensure a similar structure is developed in each community. Another respondent noted that private providers may offer different services than MCFD staff and recommended efforts to harmonize these.

A positive example of efforts to standardize practice is services for children who have experienced sexual abuse. Last spring MCFD announced changes to the standards, training and regional allocation of resources for the Sexual Abuse Intervention Program (SAIP) following a 2006 review. While a relatively small portion of the CYMH budget, SAIP has commanded public attention. The 2008 standards of practice aim to improve consistency. However, provincial office and the regions will need to ensure program changes are realized.

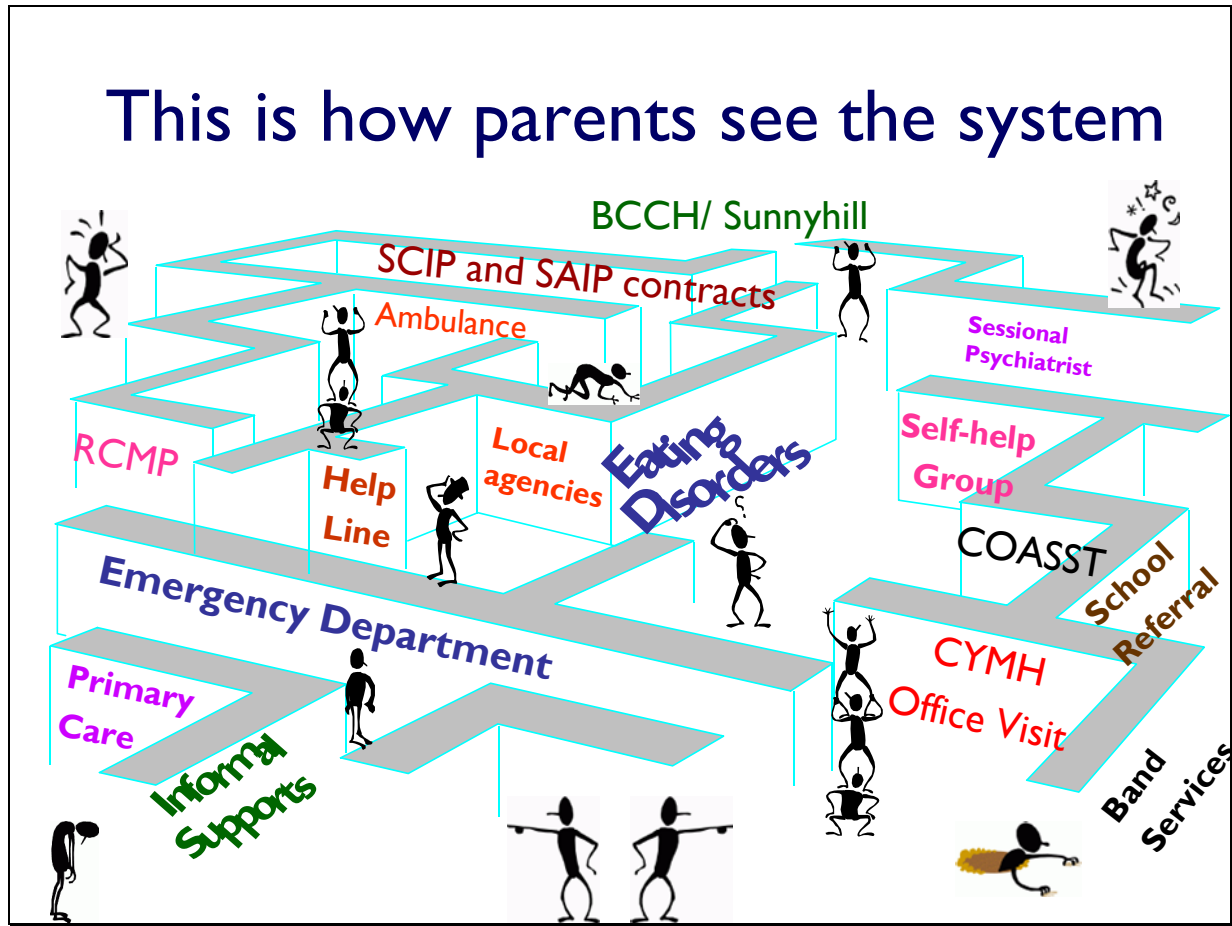
**We strongly support the on-going emphasis on evidence-based approaches, recognizing that this will require committed leadership to promote “better practice” throughout the province.**

**FIGURE 4-7 HOW PROVIDERS VIEW THE CYMH SYSTEM**



Source: Office of Auditor General. (2007)

FIGURE 4-8 THE CYMH SYSTEM IS EVEN MORE CONFUSING FOR FAMILIES





## Recommendations related to improving treatment and support:

1. **Make improved access a priority** in regional operating plans
  - **Define a basic level of CYMH services that should be available in all communities**, with specified access to more complex referral services. Map what services are available from all programs and compare this with models of ideal programs to find gaps and overlaps.
  - **Ensure that resources are adequate** to achieve the defined level of services. Set stepped targets to improve coverage of the unmet need noted in this report. Explore needs-based methods to distribute resources to support the goal of equitable distribution. If funds are insufficient, address the issue openly so that realistic plans can be developed to mitigate the impact.
  - **Set regional baselines and targets to improve waiting times** as a major focus of work.
  - Develop supports to **improve the experience of families** while they wait to be seen by clinicians.
  - Explore ways to **increase use of non-specialist staff** to increase access and offer outreach.
  - **Develop plans for after-hours care in every community.**
  - Consider ways to **create navigator services or positions** that will assist families to access appropriate services in a timely fashion.
  - Train managers to **apply process improvement methods** to increase capacity and improve access. It is particularly important to train whole teams whenever possible, to ensure they have appropriate supports and to build reflective time into group meetings to evaluate the impact of the changes (e.g. implementation of the new policy on referral and intake processes). Appendix 12 illustrates critical functions suitable for this analysis.
2. Provide **additional resources for residential facilities**, especially “step-up” and “step-down” facilities, ideally distributed all over BC. CF&CS should not control access to such homes as occurs presently.
3. Intensify activities to **improve the transitions from CYMH services to adult services.**
4. Develop regional and provincial strategies to engage physicians more effectively in CYMH service delivery.
  - Collaborate with MoHS and HA staff to **coordinate recruitment of child psychiatrists.**
  - **Work with BCMA and the College of Family Physicians of BC** to discuss collaborative approaches, particularly for education about CYMH issues within the MoHS-BCMA Practice Support Program.



5. Build on the current **clinical supervision strategy** to support front-line staff. We propose the following approaches to address these “soft” but essential aspects of large-scale organizational change:
  - Recognize the unique aspects of clinical supervision for those working with Aboriginal families. This is a complex area that may warrant dedicated resources, especially for the delicate issue of monitoring clinical supervision in contracted agencies. One Team Leader suggested using Aboriginal elders to assist with supervision. The impact of trauma on these children was also identified as a priority for supervision. In addition, developing clinician skills in ensuring their own safety can help make outreach activities more effective.
  - Use a holistic approach to evaluate both the impact of front-line work and the effectiveness of clinical supervision. Recent work in some regions with peer chart audits is a promising start.
6. Continue the emphasis on **training staff in evidence-based practice**. Novices learning how to organize their work in a new setting have quite different learning needs from current staff learning how to apply recently acquired new skills. Monitor how staff apply their new training in their daily practice and assist them to overcome obstacles. Specific topics have been identified in this report. **Ensure these are appropriately resourced**. Training for contracted agency staff should also be considered.
7. Continue **provincial leadership to ensure consistency for research, training and evaluation initiatives** that support evidence-based practice.
8. Create an **HR working group to address CYMH service strategy** including the issues of “job-ready graduates” and “graduate-ready jobs”.
9. Consider alternative **placement of CYMH services in community settings** (away from protection functions) to enhance accessibility of services.
10. Develop data capture processes and develop performance indicators, outcome measures and evaluation mechanisms to assist in **reporting on Aboriginal services and outcomes**.

## Chapter Five

### PERFORMANCE IMPROVEMENT

Performance improvement initiatives strengthen the infrastructure necessary for successful implementation of the Plan and for demonstrating achievement of objectives. Introducing a comprehensive management information system enables evaluation of activities, facilitates linkages with databases in other ministries and permits better tracking of mental health outcomes. The improvements to information technology will improve program monitoring and inform management decisions to adjust activities as needed to improve client and system outcomes.

**Establish a formal structure to better ensure coordinated planning and service delivery, across ministries and sectors, provincially, regionally, and locally.**

In our view based on the management science literature, any large-scale organization change initiative requires effective performance management. When the Plan was introduced, regional directions varied but all addressed the Plan objectives. Performance management was enhanced with regular meetings of CYMH staff from different levels, along with regular reporting with Plan progress. According to the stakeholders interviewed for this report, **the new organization structure for MCFD has had advantages and disadvantages for focused development of CYMH services.**<sup>13</sup>

<sup>13</sup> The new structure devolved many functions from direction by Provincial staff to regional managers. Within all regions, CYMH functions now report through programs integrated at the community or sub-regional level. This means that CYMH Team

The positive comments relate mostly to decision-making closer to the community-level with more opportunity for local consultation. Service integration was not mentioned as a benefit. The negative reactions arise from lack of evidence that generalized programs support growth and development of CYMH services; a fear of marginalization for CYMH; perceived loss of mandate for central policy direction and accountability for CYMH services; inconsistencies among the regional plans; and the challenges of maintaining expertise. Among the most pressing system concerns noted by Team Leaders in our survey is, “*a lack of regional management capacity and CYMH vision, leadership, and stewardship at the regional level*”.

We observed variation across the regions in the roles of Regional CYMH Managers/Consultants. One Team Leader described the advantages of dedicated support for CYMH, including program direction, a voice at the regional leadership table, and liaison with other agencies. These tasks were not feasible for busy Team Leaders and generally not possible for CSMs without CYMH experience. Regional Mental Health Managers/Consultants are usually not authorized for these functions. As a result, even gathering data for this review was extremely difficult. We recommend that **each region should have a CYMH Lead** with a specified management role as detailed in the recommendations below.

Leaders report to Clinical Service Managers who are also responsible for other MCFD programs.

The key issues for stakeholders we spoke with are **careful coordination and sufficient management capacity to steer a large-scale initiative** such as further evolution of CYMH services. There is a Provincial CYMH Policy Advisory Committee [CYMH-PAC] consisting of the Director of CYMH Policy, the Director of the Regional Support Council, Director, Maples Adolescent Treatment Centre, Director, Youth Forensic Psychiatric Services, the Regional Mental Health Managers/ Consultants, a Team Leader from each region, with CYMH Provincial Policy team staff in attendance as appropriate. (Membership is being revised and will include Aboriginal CYMH representation and possibly representation of other stakeholders.) Several MCFD staff we spoke with expressed concern about the ability of this group to affect regional operations related to CYMH.

We think it important to **ensure that successful regional initiatives can be replicated** across the province. This is a potentially positive consequence of the variation noted earlier. It is not helpful if each region develops its own plan in isolation from the good work developed elsewhere. Every opportunity should be made to recognize local successes. These “beacon sites” should be analyzed to isolate factors that can be replicated and scaled up for wider application.

The relatively small size of the CYMH Program, within a modest BC population scattered over a vast geography also leads to **concerns about critical mass**. Some people are concerned that small but vital issues such as CYMH services for Children in Care or for the dually diagnosed would not typically arise in a community-planning dominated structure. In developing strategy

there will need to be a balance between a centralized and a regionalized approach to priority setting. For some of the CYMH teams, (e.g. Aboriginal teams) their small size means that they lack appropriate office space and support staff.

There may be some benefit in **developing an inventory of all child and youth mental health services provided in each region**, including those funded by MCFD, MEd, MoHS, MHLS, Ministry of Attorney General, Ministry of Income and Employment Assistance, United Way, and private donors. Some communities have already started this work.<sup>14</sup> We recommend that this “asset mapping” should be accompanied by a financial or resource inventory that tracks all funding sources for related work. This detailed and comprehensive picture of the total spend in child and youth mental health services would assist in equitably sharing population-based funding and other strategic investments that link programs across government and across communities. We recognize that “opening the kimono” in this way will require a level of trust that may not always be present. Notwithstanding the risks, some communities have already made bold moves in this direction, including joint funding proposals and closer resource sharing. In future, RFPs based on new funding could require greater transparency. To achieve this, it will be necessary to develop consistent service line codes to track specific CYMH positions funded with MCFD funding.

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<sup>14</sup> E.g. “Communities that Care” is a community mobilisation initiative aimed at reducing adolescent health and behaviour problems. It helps communities assess their risk & protective factors and implement programs that work across silos. The CYMH Plan funded MCFD staff participation in Squamish.

Several sources commented on the **problems arising from the regional focus on child protection**. This focus is seen as not only distinct, but sometimes at odds with the needs of families with CYMH concerns:

*“Protection services and mental health do not meld well together: They are a house divided. Part of the problem appears to be that the Community Services Managers come from the child protection side and therefore there is little voice or representation for mental health.”*  
(Community advocate).

MCFD managers noted that the voluntary nature of most CYMH services differ from the non-voluntary aspect of protection services. They also commented that CYMH staff sometimes appear to view themselves as “special” or “separate and apart” from other MCFD colleagues. Although we heard of instances where the departments collaborate effectively, especially where co-location facilitates relationship building, this issue requires further attention. We recognize the challenges inherent in this issue. Indeed, there is likely no perfect solution, especially given family views about “connecting the dots” or coordinating services as noted above. **Joint training, protocols for information-sharing, agreements about access to residential resources, and shared understandings about priority referrals** may address key areas of friction.

**Senior leadership support is seen as lacking by most stakeholders internal and external to MCFD.** In its 2007 report, the Office of the Auditor-General recommended that MCFD executive should “ensure that there continues to be strong leadership for child and youth mental health services” (p.3). Senior MCFD officials explained that CYMH is not a “back-burner” issue for

them personally. Unfortunately, though, CYMH does sometimes suffer amongst the many demands of large and complex portfolios. As a small yet specialized program delivered over a large geographic area, CYMH faces unique challenges (as do Adoption Services and other small programs). Balancing clinical specialization standards with responsive community delivery is the central challenge. The REDs that we spoke with were universally positive about the impact of the Plan and its importance in their regional strategy.

MCFD managers were less clear about leadership support. One stated, “*We need to see congruence between the leadership messages and the behaviour required of staff.*” This referred to the disconnect between statements and expectations in areas such as, reducing paperwork, valuing collaborative community work, participation of families and involvement of Aboriginal communities. MCFD staff and community stakeholders would benefit by **hearing more from the MCFD system leadership group about their vision for developing CYMH services.**

Taking a leadership role could also include frank acknowledgment that much work remains. “*On a scale of 1 to 5, we are at about 1.5,*” as one RED stated. This realistic approach helps staff and community members engage with the issues that will lead to long-term system changes. More broadly, MCFD leaders should acknowledge their commitment to CYMH issues, in the context of responsibilities properly belonging to other government Ministries, and indeed, all of society. **The complex web of factors that causes mental health issues at the level of individuals and communities is not the sole responsibility of MCFD.** “*Investments in children's mental health are surely among the most important investments that any society can*

*make*” (McEwan, Waddell and Barker 2008). If accepted, this statement should lead to a higher profile for CYMH within MCFD with identified leadership roles at all levels.

**We heard strong concerns related to the lack of a formal accountability framework or quality assurance model for CYMH services.** This perception is interesting since MCFD staff have reported extensively on this issue:

- An accountability framework for the CYMH Plan, developed in the form of a program logic model, was approved by the Assistant Deputy Minister, Provincial Services, in February 2006. The framework identifies key implementation strategies, expected outputs and outcomes. Intended outcomes are specified at both the client and system level.
- In 2006, CYMH Policy Team staff developed a report for Treasury Board on progress with the Plan.
- The Auditor General conducted a review of progress with the Plan in 2007.
- CYMH Policy Team staff prepared a Progress Report that was widely distributed to stakeholders in 2008.
- Going forward, the accountability mechanism for CYMH staff will be guided by the MCFD Strong, Safe and Supported Operational Plan. In addition, a comprehensive cross-Ministry strategy for monitoring and reporting on child and youth outcomes is planned for spring 2009.
- Preliminary outcome data are available from BCFPI. Additional information will be available when the implementation of CARIS is completed and CARIS reports become available.

- MCFD-CYMH is providing funding to the Children’s Health Policy Centre at Simon Fraser University for a monitoring project to measure trends in the mental health of children in BC that will include use of data from MCFD, MoHS, MEd, and Pharmacare etc. (Results are not yet available.)
- We heard about quality improvement initiatives in some areas, including for instance, staff surveys about performance measures, surveys and focus groups for families and youth, and peer-led chart audits. However we were unable to determine whether this was consistent practice as part of a coordinated plan across regions, or locally driven.

**Nonetheless, the absence of any formal performance monitoring mechanism remains a concern.** There are high expectations among some community groups for the recently created role of Assistant Deputy Minister for quality assurance. As noted previously, some people were puzzled that there has not been wider promotion of government’s success with the CYMH Plan. Others were more critical that the Progress Report was deficient in detailing the implementation specifically. Generally, there is an expectation that the regions will report publicly on investments in CYMH services.

**The continuing workforce shortages require robust succession planning for recruitment and retention.** Some Northern providers said that MCFD should “get creative” with distance education. Distance delivery would keep staff closer to work while they are training and help ensure that skilled staff stay in the North as they upgrade their skills. Community agencies noted however, that recruitment incentives offered by government departments



(especially MoHS) are a significant challenge that they can simply not meet with their budgets.

**Develop and implement an information technology plan to facilitate program planning, service coordination, quality assurance, research, collaborative networks and education.**

Although most external stakeholders are unaware of the information and communication technology [ICT] issues in detail, we did hear from them that communication among MCFD departments is sometimes troublesome. The greater concern comes from MCFD staff, many of whom mentioned that **using the new Community and Residential Information System [CARIS] is problematic**. Frustration over the time requirements and problems associated with CARIS implementation were reported by 76% of survey respondents among front-line staff.

Provincial and regional CYMH staff report that **several issues led to weak implementation of CARIS**; some of their key problems include:

- Lack of aggregate reports at the office, regional and provincial level meant operating without concrete feedback regarding the implementation of CARIS. This greatly hindered the identification of problem areas and needed support. Lack of aggregate reports continues to be a serious problem.
- Expecting that training and brief support would suffice with a complex system may have been incorrect given the infrastructure problems. Many staff, even one year later, struggle with how CARIS works. This has been made worse by the inconsistent performance of CARIS.

- The initial plan indicated that the first year would be used to collect information from clinicians and field staff on how CARIS needs to be improved to best fit with policy and practice. Unfortunately, this has not happened as the first year dealt primarily with on-going and serious performance issues, and as there appears to be insufficient funding available to make the improvements needed, or complete the requirements as intended.
- Lack of capacity in the regions to support the implementation has been an issue. This includes some confusion about channels to tackle problems, leaders' understanding of issues, and accountability. In addition, communication was challenging, as staff did not always respond to advice.

**In other words: good idea; poor realization of benefits so far.** Within MCFD, accountability for implementing the ICT plan appears unclear to us. Once the system parameters have been established with policy and clinical input, it is probably more appropriate that the on-going accountability for the system rests with ICT experts centrally and regionally. We did not review this topic in detail, but would **recommend an in-depth analysis of the issues related to CARIS**, including its relationship with the recently announced Integrated Case Management ICT initiative.

The **Brief Child and Family Phone Interview [BCFPI] is a clinical intake screening tool** that has already been introduced in other jurisdictions in Europe and Canada, including Sweden and all provincially-funded children's mental health services in Ontario, and is now being introduced to children's mental health services in Nova Scotia. Implementation in BC started in 2005 as one of the ICT enhancements introduced through the Plan. In addition to standardized screening, BCFPI creates various levels of reports so that all levels of the organization, from

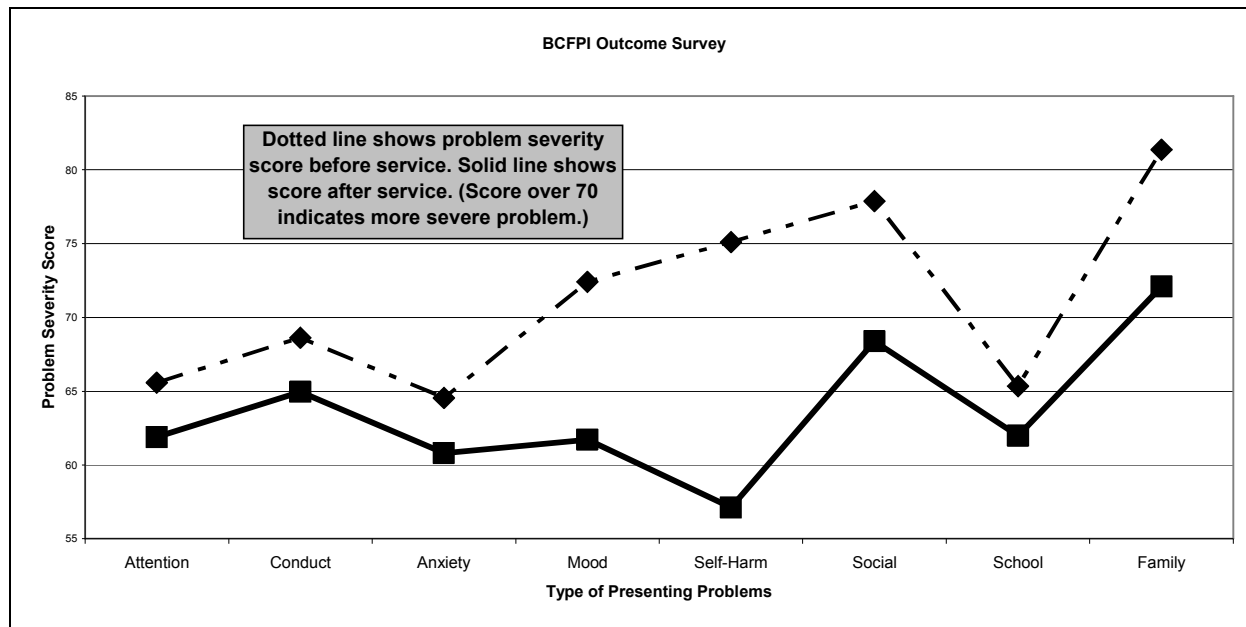
policy and management to supervisors and line staff, can access data for outcome & service delivery analysis. Additionally, reports will allow analysis of changes in intake prevalence rates, local and regional differences in presenting problems, trends, and specific gaps in service delivery. Some managers report that they are already finding the BCFPI useful. Front-line staff are happier with BCFPI than with CARIS, but some still doubt its usefulness as a structured screening instrument. **Although BCFPI seems to be less problematic than CARIS, we heard these concerns.**

- CYMH Policy Team staff note that full implementation of the BCFPI has been negatively affected by **technical infrastructure difficulties related to the implementation of CARIS**. These problems have interfered with clinician access to the BCFPI and the consistent use of the follow-up survey and use of reports.
- Some community agencies commented that **parents feel frustrated** going through the process because it does not necessarily lead to action for a situation that they feel to be problematic. One advocate commented, after a long interview process, the worker tells the parent, *“Thank you very much, we will get back to you to see whether your child qualifies for service.”* They also observed that BCFPI seems to be used somewhat differently by various staff.
- Some Aboriginal service providers noted that the BCFPI process **does not work well**

**with their clients, who need a more inclusive, less formal process** to build trust. For the many Aboriginal grandparents who are raising children and youth, the technology and language of BCFPI can be a serious barrier to access.

Several stakeholders observed that **front-line staff should be using information management tools like BCFPI** as necessary and helpful aspects of their daily work. We agree. Continuous learning, monitoring and public reporting all require solid data. Data can also help show which interventions support better outcomes. As shown below (Figure 5-1), BCFPI can produce reports showing not only the services offered to various populations, but the impact of those services. The graph comes from a recent outcome monitoring study conducted by the Children’s Health Policy Unit at Simon Fraser University, which used BCFPI data collected by CYMH teams in all five MCFD regions to compare the status of children and youth at intake and at six month follow-up (Chen, 2008). Figure 5-1 shows significant reductions in all mental health symptom and functioning problem areas. The study also demonstrates the capability of the BCFPI to provide treatment outcome data that are useful at a team, regional, and provincial level to improve our understanding of the clinical and functional profile of children served by CYMH services.

**FIGURE 5-1 BCFPI HAS THE POTENTIAL TO PRODUCE HELPFUL DATA**



Acknowledging the “growing pains”, MCFD staff report that they have taken a number of steps to **address the issues associated with BCFPI**:

- CYMH Policy Team staff consulted widely in all five regions during fiscal year 2007-08. They incorporated feedback and recommendations into policy development and local procedures. These changes will also be considered in the next software upgrade for BCFPI due in August 2008.
- An Intake Policy Reference Group is revising intake policy and clarifying the use of the BCFPI in the context of intake, including consideration of cultural and clinical needs for each youth or family.
- Since some regions experience more success with BCFPI than others do, it would be helpful to share the lessons learned. Further consultation sessions are planned in each region to improve the use of aggregate reports and implementation of the follow-up survey to measure service outcomes.

**We strongly recommend continued use and development of BCFPI.** CYMH Policy Team staff have recommended a number of measures to improve CARIS performance. Continued training and additional resources are clearly required. **We think it important to assess progress with CARIS and if it is still to be used, then reinforce the resources devoted to implementation of both CARIS and BCFPI and assign responsibility and accountability for successful implementation to MCFD’s IM/IT Branch.** Additionally, if CYMH is to be included in the integrated case management system now under development, it will be important to ensure that the data requirements and reporting mechanisms are feasible and relevant for CYMH.



**Telehealth** was described by one psychiatrist as an excellent adjunct to outreach sessions in smaller communities. It is well received by patients and well supported in the literature. Apparently, sessions for telepsychiatry have been reduced by MoHS since the service began in 1995, although we were not able to validate this. The Family Help Program developed by Dr. Patrick McGrath in Nova Scotia seems particularly relevant for the BC setting. This provides education and treatment using trained coaches through telephone contact, written manuals, videotapes, and audiotapes.

MoHS and MHLS staff working on the proposed Mental Health and Substance Use Plan have developed a website to link providers in a “**Community of Practice**”.<sup>15</sup> Rather than duplicating with a separate site, it might be helpful, at least initially, to participate in the knowledge-exchange work that has already been started.

**Develop an evaluation plan and collaborate with children’s mental health researchers in a variety of settings.**

We heard **many positive comments about the emphasis on evidence-based practice** and the importance of on-going research to guide practice and report on results. The

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<sup>15</sup> A “community of practice” is an informal group of professionals, tackling common problems and common pursuit of solutions through various knowledge transfer methods. Communities of practice usually try to work with the same tools and express themselves in a common language with a shared purpose. Benefits are increased capacity, faster spread of better practices and shared resources, all leading to greater visibility and impact.

longstanding partnership with SFU’s Children’s Health Policy Centre was specifically cited as a smart move.

However, the absence of measurable objectives such as targets – indeed the **lack of any formal evaluation of Plan activities - is a serious concern** for many respondents. Many of the initiatives included in the Plan are known to be efficacious; that is, they have been shown to work in other settings. For MCFD, the issue is effectiveness: Can the proven techniques work in the BC context, and if not why not? Knowledgeable insiders such as academics, specialist providers and advocates particularly noted the absence of input, output and outcome data.

Team Leaders recommended taking stock of what has and has not worked through a **formal evaluation of CYMH Plan initiatives as a means of guiding future direction**. So far, there have been only piecemeal evaluations of certain Plan components. The Progress report was discounted for its “case-study orientation”. We heard,

*“The regional services should be made accountable and transparent.”*

*“As much as the monthly regional progress reports [on implementation of the Plan] were a pain, they kept me on track and focused on where we were supposed to be going.”*

*“Evaluation should include community feedback as a collaborative process.”*

**We recommend** that the new MCFD regions should be made accountable for specific deliverables related to CYMH services as agreed in annual operating plans.

We recognize that many urgent issues draw attention away from long-term planning. Therefore, **each region should be required to develop a clear and detailed implementation plan** that responds to findings and recommendations of this report.

Several sources recommended more research based on long-term epidemiologic surveys. The Children’s Health Policy Unit at Simon Fraser University has been funded through the Plan to conduct a monitoring project that will enhance our ability to assess priority topics such as:

- Significance of social determinants of health;
- Outcomes of intervention approaches;
- Impact of strength-based approaches;
- Impact of FRIENDS;
- Monitoring of population health indicators such as suicide and school completion

Implementation problems with the new information technology hampered development of this report. Long-term, **an external outcome measurement system should be developed** as a permanent resource to develop robust surveillance tools common to other public health concerns. “*We need the data,*” as one clinician emphasized. Recognizing the long periods required, it would be sensible to link CYMH data to the larger Canadian Institute for Health Information framework. Then, for instance, more complex policy issues could be analyzed, such as whether particular treatment approaches are working effectively and how service provision may need to evolve. In addition to the value for epidemiologic and service planning purposes, the evaluation program then becomes an economic tool, to rationalize resources and their benefit.

Quality assurance is one of the functions recommended by some stakeholders for the CYMH Policy Team and the Regional Support Council; alternatively, it may be a function of the new Quality Assurance division. This **accountability at arms-length from regional management would help ensure that performance measures are applied consistently**. Several people suggested that this accountability should be based on both transparent processes and input from multiple sources: BCFPI, CARIS and other measures would provide objective data about services provided. Some programs such as CBT, which are prescriptive, are particularly amenable to formal evaluation. Providers, clients, families and partner agencies would provide subjective data about staff, family and client satisfaction.

**In general, client satisfaction is poorly evaluated** in most health services in BC, and MCFD’s CYMH service is no exception. Some basic elements of professional courtesy require monitoring and follow-up. For instance, we heard reports of clinicians not returning parents’ phone calls for a week; and of discharge from hospital with no preparation for services at home. We recommend a routine practice of third-party satisfaction surveys based on meaningful topics with direct feedback to regional managers about team performance (e.g. see <http://www.pickereurope.org>).

Some people asked **why accreditation processes do not apply to CYMH services** as they do to similar programs in the health system. One provider said, “*CYMH is the only health service that is not accredited by any agency or national body. This would not happen in any other branch of health service.*” Several people felt that within the new regional delivery structure, there should

be an external validation process with checks and balances based on national standards. In this way the public would be assured that there is a feedback mechanism free of internal influence.

The final word on this subject comes from a service provider working in one of the HAs:

*“We [providers] all have an accountability to communicate. Especially we should be able to communicate with our clients about where they are starting from and where we expect them to change, and how their lives will improve as a result of our work together.”*

## Recommendations related to performance improvement

1. **Strengthen the impact of current and robust data on all aspects of CYMH services.** Routinely use the information as the basis for management and budget decisions (obviously, having the information but not using it is unhelpful.)
  - **Make a business decision about continuance of CARIS.** If it is to be continued, reinforce the resources devoted to implementation of both **CARIS and BCFPI** and ensure accountability of MCFD’s IM/IT Branch.
  - We recommend **continued use and development of BCFPI.**
  - **Create an outcome measurement system** as a permanent resource to develop robust surveillance tools common to other public health concerns.
  - Make a routine practice of **client satisfaction surveys** based on meaningful topics with direct feedback to regional managers about team performance
2. In the interest of strengthening management of the CYMH activities, we recommend **managing the emerging matrix organization more proactively.** The challenges of managing small, specialized programs in a large regionally-organized structure have been discussed above. Although details are beyond the scope of this review, we offer some recommendations based on health sector experience with this issue over the past two decades.

On the surface, the issue is straightforward: central policy areas are responsible for legislation and policy; regional managers are responsible for planning and implementation of local services. **Problems arise when organizational leaders and operations managers lack expert knowledge about the front-line work, which is often performed by staff members with post-graduate degrees in the subject.** This is

not unique to children’s services, indeed it was the reason that “matrix” organization models developed in the aerospace industry in the 1970s. Experts (or “knowledge workers”) typically know more than their senior managers about cutting-edge practice; they need professional development opportunities with similar colleagues; their individual selection and evaluation criteria require expert knowledge, as does the design of their program evaluation.

**TABLE 5-1 PERFORMANCE MANAGEMENT AND ACCOUNTABILITY: WHO IS IN CHARGE OF WHAT?**

<i>Draft for illustration only</i> What are the jobs to be done?	Policy Team	Regional Support Council	Regional Operations	Quality Assurance
disseminate “better practice”	R	I	I	I
set & communicate standards and policy	R	C	C	C
monitor compliance and outcomes	C	I	C	R
track corrective action	C	I	R	C
allocate capital and operating funds for current programs	I	I	R	I
allocate capital and operating funds for new programs	I	C	R	I
support staff with program requirements	C	C	R	I
inter-ministerial system development	C	C	R	I
provincial system: identifying issues, responses and strategies	R	C	R	C
provincial system: locus for stakeholder relations, commissioning advocacy, research and communications support	R	I	C	I
provincial system: developing plans	C	R	R	I
provincial system: implementing initiatives	I	C	R	I
<p><b>R = responsible to lead</b> This organizational unit is responsible for making decisions. It assumes ownership of the decision-making process.</p> <p><b>C = must be consulted</b> Input into the decision is required on a timely basis from this organizational unit. Staff of the unit are expected to provide comments and feedback before any decision is made or approval granted, in order to render advice or relate information.</p> <p><b>I = must be informed</b> Input is not required from this organizational unit. Individuals or organizational units in this position may be informed of the decision before or after the fact.</p>				

Matrix organization is designed to deal with these issues that arise from the complexity of large knowledge-based organizations (Table 5-1). The primary purpose of a matrix structure is to focus on system-wide improvements, beyond the “urgency” perspective of operations managers. The matrix structure makes it possible to decentralize operations while maintaining consistent delivery and best practice standards across the system. It relies on but also improves communication, accountability and teamwork. These all contribute to better coordination, better use of resources, and a more fulfilling work environment.

**We recommend** that **all regions should have a regional “CYMH Lead” (exact title to be determined)**. This will formalize some of the existing arrangements and ensure that in each region there is a designated leader (or, “go to” person). To be effective, this position should be a member of the regional executive team, sharing authority with Directors of Integrated Practice [DIP] and Community Service Managers [CSM] regarding sub-regional program development. This position should also link closely with the Regional Support Council and the CYMH Policy Team. This cross-matrix linkage will help ensure that regional variation informs provincial policy and appropriate supports are provided.

We suggest that the CYMH Leads should provide regional leadership for CYMH in collaboration with CSMs and CYMH Team Leaders for the following activities:

- Developing the deliverables for RFPs and Performance Agreements;
  - Guiding the monitoring and review process for agency-contracted services;
  - Managing short-term projects (such as training programs for new staff);
  - With CYMH Policy Team, developing recruitment standards, orientation activities, on-going training, and appraisal tools, especially to ensure competence and cultural safety in all settings;
  - Ensuring that effective clinical supervision and clinical audit processes exist;
  - Developing population and program data sources for evaluation and planning;
  - With CYMH Policy Team, developing reporting requirements for CYMH services;
  - Supporting regional human resource planning activities.
3. In addition we suggest the RED Council consider other formal mechanisms to manage large-scale organizational change. Specifically,
- **Discuss from a strategic perspective how to respect both diversity (the unique aspects of BC’s many communities) and standards (evidence-based practice that delivers consistent positive outcomes for all residents).** In other words, “How do we avoid a ‘postal-code lottery’ situation, in which quality of service depends on where you live in BC?”



- **Information and Communication Technology Table** responsible for overseeing the implementation of BCFPI, CARIS and related components of the MCFD Information Strategy, and influencing the information strategy from a service perspective.

Clearly, on some issues there will be overlap between operational and program accountability. Matrix organization relies on communication and trust as a foundation for shared decision-making. Senior management plays an important role in facilitating communication and supporting collaboration and consensus-building. There should be a formal process to clarify roles for CYMH functions.

6. Each region should develop a clear and detailed implementation plan that **responds to findings and recommendations of this report**.
7. We recommend that the Leadership Council should **formally adopt a principle of protecting or “ring-fencing” CYMH Plan funds** to provide assurance to stakeholders that “slippage” due to recruitment difficulties will not be lost permanently to other programs. Significant system change usually requires focusing on targeted initiatives. While regional discretion is important, we recommend a provincial perspective to address key concerns.
8. As a final recommendation, we summarize points made in several earlier suggestions: **Significant improvement in CYMH services will require the dedicated commitment, attention and follow-through by Ministers and by the senior leadership group of MCFD and other Ministries**. There are many competing demands, to be sure. The outstanding work to date can only progress if leaders demonstrate vision and grip.



## Chapter Six

### CONCLUSION

We commented earlier on the fundamental message from all the stakeholders interviewed: **The CYMH Plan presented a great vision and the approach is based on strong fundamentals.** Given the reported state of the CYMH system when the Plan was introduced, it is remarkable how much has been achieved. That said, there was general agreement that much work remains. This is a long journey, not to be completed in five years only. **All the stakeholders, internal and external, also know that more resources will be needed.** No less important is the call for leadership. People in the field believe that a firm grip steering the system will be required to address the principles of the Strong, Safe and Supported Plan.

The preceding chapters of this report describe our findings in relation to the objectives of the review. In this concluding chapter, we summarize the key themes. To begin, four objectives were identified when this review was commissioned (detailed on page 20 above). We will address those issues directly:

1. Based on the direct experiences of the children, youth, and their families that we surveyed, **the overall child and youth mental health service system is clearly inadequate in many respects.** This is a difficult finding, both because of the reality for clients and families, and because so many MCFD staff have worked very hard to improve the situation. There may be some comfort in knowing that many community partners appreciate the effort. To some extent, it is a success of the Plan that the scale and scope of CYMH problems are increasingly recognized by communities.
2. **Current stakeholder perspectives on the child and youth mental health service system are remarkably similar to priorities identified in the earlier consultation process** conducted prior to the Plan (Appendix 2). This is not surprising, given the nature of those priorities. The Plan addressed these systematically; however, additional efforts will be needed through the next phase of work on CYMH issues.
3. **The CYMH service system clearly advances broader MCFD objectives** including a) adherence to a strengths-based development approach and b) consistency with the transformation agenda including better-integrated programs and services, provincial support for the regions, and improved working relationships with Aboriginal communities. In some respects, the Plan anticipated the strengths-based approach, particularly with the emphasis on community capacity-building. Issues related to the transformation agenda require bottom-up and top-down approaches to be effective.
4. We have detailed in preceding chapters **the positive impact of CYMH Plan implementation on the strategic shifts** (reducing risk; building capacity; improving treatment and support, and improving performance). The emphasis on “upstream” or preventive work and evidence-based practice are probably the most successful strategic shifts, while the “improving performance” area has made least progress so far.

Next, we summarize the major recommendations from earlier chapters, organized as short-term and longer-term priorities. Please see previous sections for the full detail of the recommendations.

## PRIORITY SHORT-TERM RECOMMENDATIONS

1. **Strengthen mental health promotion and risk reduction initiatives** (such as FRIENDS and home visitation programs) with additional resources where needed and improved collaboration with other ministries.
2. Reinvigorate the **CYMH Network Committee**.
3. There should be a commitment to **embed client and family perspectives** and resources into the infrastructure both regionally and provincially, with a policy on expectations of family advisory committees at the regional and sub-regional level.
4. Because it is a shared issue, **MCFD, MoHS and MHLS will need to work closely in detailing and rolling-out the proposed Ten Year Mental Health and Substance Use Plan**.
5. **Improving services for concurrent disorders among children and youth** requires involvement of senior staff from several Ministries.
6. **Make improved access to services and waitlist management a priority in regional operating plans**. We see much potential in focusing on this goal, but it will require regional leadership, a commitment to process improvement and some resources.
7. Provide **additional resources for residential facilities**, especially “step-up” and “step-down” facilities, ideally distributed all over BC.
8. We recommend **continued use and development of BCFPI. Make a business decision about continuance of CARIS**. If it is to be continued, reinforce the resources devoted to implementation of both CARIS and BCFPI.
9. Every region should have a **regional “CYMH Lead”** (exact title to be determined). This position should be part of the regional executive team, sharing authority with Directors of Integrated Practice and CSMs regarding sub-regional program development.
10. The **regions should be accountable for specific deliverables** related to CYMH services as agreed in annual operating plans. Each region should develop a clear and detailed **implementation plan that responds to findings and recommendations of this report**.

## PRIORITY LONGER-TERM RECOMMENDATIONS

1. Develop **an effective structure to engage partners and stakeholders** to tackle CYMH issues across government
  - a. The **Minister’s External Advisory Committee on CYMH should be renewed** with regular meetings.
  - b. **Attendance of MCFD staff in school settings** requires discussion at a provincial level to develop clear guidance for local collaboration.
  - c. A cross-Ministry task group should be provide **guidelines regarding sharing of client information**, following direction from the Provincial Privacy Commissioner.
  - d. Some portion of **any new CYMH resources should be “ring-fenced” or protected for collaborative projects**.
  - e. Intensify activities to **improve the transitions from CYMH services to adult services**.
  - f. Develop regional and provincial strategies to **engage physicians more effectively** in CYMH service delivery.
  - g. Build on the current regional committees and **CYMH-PAC sub-committees** to ensure that CSMs and Team Leaders have venues to address specific operational issues.
2. **Strengthen Aboriginal CYMH programming.**
  - a. Continue **collaborative planning with Aboriginal community stakeholders** to develop services that build on community strengths and are culturally relevant.
  - b. Develop data capture processes and develop performance indicators, outcome measures and evaluation mechanisms to assist in **reporting on Aboriginal services and outcomes**.
3. Maintain momentum with **human resource development** to enhance CYMH services
  - a. **Build on the current clinical supervision** strategy to support front-line staff.
  - b. Create an **HR working group** to address CYMH service strategy including the issues of “job-ready graduates” and “graduate-ready jobs”.
  - c. **Continue the emphasis on training staff** in evidence-based practice. Ensure these are appropriately resourced. Training for contracted agency staff should also be considered.
4. **Strengthen information management and research** to promote evidence-based practice.
  - a. Create **provincial leadership to ensure consistency for research, training and evaluation initiatives** that support evidence-based practice.
  - b. Create an **outcome measurement system** as a permanent resource to develop robust surveillance tools common to other public health concerns.
  - c. Make a routine practice of **client satisfaction surveys** based on meaningful topics with direct feedback to regional managers about team performance.

To conclude, we summarize the theme of several earlier comments:

**Continued improvement in CYMH services will require commitment, resources and follow-through by several Ministers and by the senior leadership group of MCFD and other Ministries.**

There are many competing demands, to be sure. The outstanding work to date can only progress if three critical factors exist:

- 1. Sustainable funding;**
- 2. Consistent evidence-based policy and practice;**
- 3. Leadership vision and grip.**

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## Stakeholders consulted for this review

The following individuals participated in discussions with the project consultants. Most were members of focus groups (n=240); some (those starred\*) were interviewed individually (n=37). We are grateful for their participation and their willingness to share their knowledge and enthusiasm for improving services for children, youth and their families. Thank you.

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## Findings of the CYMH Consultation Process (October 2000)

“The following common themes were identified throughout consultations with individuals and groups, described previously, across the system of care related to mental health services for children, youth and families.

- Need for the development of infrastructure to support the implementation of changes within the current Child Youth and Family Mental Health system, and the facilitation of collaborative partnerships.
- Need to involve clients and families in an advisory capacity on a provincial, regional and local level, and to provide additional support and education to families whose children have mental health needs.
- Specialized, qualified, multidisciplinary mental health staff are required to deliver a range of mental health services across the province.
- Improved coordination of services within MCF e.g. mental health residential resources, coordination of service for complex dual diagnosis cases is required.
- Improved partnerships are required with Ministry of Health, Ministry of Education, physicians, and other system partners e.g. bridging the gap between adult and child and youth mental health systems to address issues of common concern such as transitional services for youth age 15-24, improved school-based services, early screening and other mental health services for children under 12 years.
- Ongoing educational needs such as:
  - Education for the general public to increase awareness of CYMH services and mental health issues, and reduce associated stigma.
  - Specialized education for mental health clinicians e.g. in cultural sensitivity, treatment for dual diagnosis, Integrated Case Management.
  - Mental health education for other service providers e.g. school counselors and teachers, physicians, alcohol and drug counselors.
- New services cannot be provided without substantial additional resources.

## CONCLUSION

The consistent expression of the need for additional resources cannot easily be ignored if the wellbeing of our children, youth and families is to be considered. Clearly, there is a great deal of knowledge within the service delivery system and in the community of the current needs and priorities, including the importance of the required infrastructure and relationships to support further development. The healthy future of many children, youth and families depends on the shared commitment of service providers, consumer groups, and provincial ministries to implement the *Child and Youth Mental Health Plan*.”

Source: British Columbia, Ministry of Children and Family Development (2000).

## Parent Survey Summary<sup>17</sup>

In June 2008, parents of children and adolescents with mental disorders were invited by The FORCE and CMHA branch offices to respond to a short survey looking at all child and youth mental health services in the province, whether offered by MCFD or other community or hospital providers. The offspring of parents involved with these organizations are likely to have conditions that fall towards the severe end of the continuum. Eighty-nine parents completed the survey. The majority had accessed services for their son or daughter through physicians: family doctors (86.5%), psychiatrists (68.5%), and pediatricians (56.2%). **It is important to note that only slightly over half (58.4%) had accessed MCFD Child and Youth Mental Health services.** Thirty-one percent had used hospital or residential services and one-quarter (24.7%) had sought help through emergency departments.

Satisfaction with the **ability to access mental health services** through any source for their child/youth was poor. Only 34.2% reported being *satisfied* or *very satisfied* while 54.9% were *dissatisfied* or *very dissatisfied*. Satisfaction with the **quality of care** received through these services was marginally better with 44.4% reporting being *satisfied* or *very satisfied*. A sizeable minority (18.5%) were uncertain regarding their satisfaction with care quality, while the rest were *dissatisfied* or *very dissatisfied*. However, when asked whether the services had made a **positive difference in their child's ability to function at home and at school**, the majority reported *some difference* (61%) or a *significant difference* (13.4%). One in every four respondents (25.6%) reported *no difference*.

In terms of satisfaction with the **communication and coordination between different service providers**, satisfaction was again very low with only 25% responding as *satisfied* or *very satisfied*. A considerable proportion of parents (25%) were *uncertain* about this aspect and half (50.1%) were *dissatisfied* or *very dissatisfied*. These sentiments were further reflected in the **ability to obtain important information** (such as diagnosis, treatment, care planning, implications for school) about their son and daughter where again half of parents surveyed were *dissatisfied* or *very dissatisfied*.

With regard to parents' **ability to be involved in the care planning for their son and daughter**, two out of five (40.8%) were *satisfied* or *very satisfied*, 38.2% were *dissatisfied* or *very dissatisfied*, and 21% were *uncertain*.

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<sup>17</sup> This survey was prepared and developed by Kimberley McEwan PhD.

The most common specific concerns regarding the provision of mental health services for children and youth documented by parents were as follows:

- Difficulties accessing appropriate care and long-wait times for service;
- Insufficient support to navigate a complex formal care system and to secure services which were appropriate to the client need;
- Lack of coordination among providers within the system;
- Limited information for families and inadequate communication;
- Transitioning from youth to adult mental health services;
- Limited opportunity for early intervention so that problems progress.

## APPENDIX 4

### Team Leader Survey Summary<sup>18</sup>

In June 2008, 65 team leaders and associate team leaders responded to a survey developed, as part of the system-wide CYMH Review, to provide a channel for input from all CYMH team personnel who function in a supervisory or leadership role. Team leaders were asked to rate a number of aspects of the service system subsequent to implementation of the CYMH Plan.

Areas where half or more of survey respondents rated the system as “better” or “much better” include:

- Evidence-based practice (92.3%)
- The range and level of core mental health services in their region (86.1%)
- Education of families and the public (83%)
- Early intervention services (82.8%)
- Community capacity to support children’s mental health (76.5%)
- Involvement of families/caregivers in treatment (71.5%)
- Integration of CYMH services with other community services (70.3%)
- Formal risk reduction strategies and programs (67.2%)
- Performance monitoring and accountability (64.7%)
- A strengths-based developmental approach to children’s mental health (63.1%)
- The gap between need and service capacity (56.9%)
- Aboriginal risk reduction services (52.4%)

Areas where more than half felt the system was “unchanged”, “worse”, or “much worse” include:

- An appropriate continuum of residential services (92.2%)
- Effective linkages with primary health care (59.4%)
- Transition from child and youth to adult mental health services (78.1%)
- Regional planning and management capacity (53.2%)
- Information technology (59.5%)

With respect to “the most pressing system concerns” and “challenges in continuing the work of the CYMH Plan”, survey respondents identified issues that reflected their responses to the more structured questions namely: a **lack of regional management capacity** and CYMH vision/leadership/stewardship at the regional level; a **lack of confidence in new IT systems** (e.g., BCFPI, CARIS); and **insufficient access to residential services**.

Despite slightly over half of team leaders rating the gap between need and service capacity as improved, a substantial proportion singled this issue out as a significant concern. Many felt the **demand for services**

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<sup>18</sup> This survey was prepared and developed by Kimberley McEwan PhD

**continues to outpace capacity**, which was attributed to insufficient resources, increased community awareness resulting in higher referral volumes, demographics in particular communities, and a broadened mandate to see children with diverse mental disorders. It was also noted that the time required to respond to children and youth needing treatment interferes with the ability to devote efforts to risk reduction and community capacity building. Service capacity concerns in rural communities were related to difficulties recruiting and retaining staff, coverage of large geographic areas, and a lack of mental health specialists.

In terms of “next steps” for CYMH services, it is noteworthy that several respondents identified the importance of taking stock of what has and has not worked through **a formal evaluation of CYMH Plan initiatives as a means of guiding future direction**. It was apparent that many felt the **prevention and early intervention strategies** of the CYMH plan were not fully realized and require a greater commitment along with dedicated resources as these are critical to stemming the flow of demand for treatment.

## Clinician Survey Summary<sup>19</sup>

As part of the CYMH review process, 215 clinicians working within community-based teams responded to a survey in July 2008 regarding their appraisals of the service system. The regional breakdown of survey respondents was as follows: 54 (25.1%) from Fraser, 42 (19.5%) from the Interior, 30 (14.0%) from the North, 42 (19.5%) from Vancouver Coastal, and 47 (21.9%) from Vancouver Island. The majority of respondents were clinicians (91.2%), while 6.5% were outreach support workers, and 2.3% were liaison support workers. Sixty (21.9%) indicated they worked within a specialized program (i.e., early psychosis, concurrent disorders, eating disorders, infant mental health, behaviour disorders). A small number of respondents (6%) were employed as contracted equivalent personnel.

The majority expressed agreement that:

- They routinely involve families and caregivers in treatment/support (98.1%)
- They routinely coordinate with Child Welfare, school districts, and public health services (97.2%)
- They employ a strengths-based developmental approach (95.8%)
- Their clinical practice is aligned with evidence-based practice (94.9%)
- They work within a team that routinely provides education and resources to families and the public about children's mental health (78.2%)
- They work within a team that is involved in risk reduction (70.6%)
- Relevant clinical supervision is available to them (68.8%)
- They work within a team that provides a continuum of services including prevention, early intervention and treatment (67.9%)
- They have sufficient preparation to deliver culturally appropriate service (62.3%)
- They work within a team that routinely prepares transitions plans for youth aged 17 and over (54.9%)
- They routinely communicate with family doctors in the treatment/support plan for a child or youth (54.2%)

There was disagreement or uncertainty regarding:

- The adequacy of service capacity given the current demand for services (90.7%)
- Access to an appropriate continuum of residential services (84.5%)
- The ability of CARIS to improve effective management of CYMH service information (76.0%)
- The usefulness of the BCFPI as a structured screening instrument (69.0%)

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<sup>19</sup> This survey was prepared and developed by Kimberley McEwan PhD



With respect to **whether clinicians believed the CYMH Plan has significantly contributed to improved mental health outcomes** for children and youth in BC, 59.1% either agreed or strongly agreed, while 34.4% were uncertain and 11.1% disagreed.

Major issues and gaps in the provision of CYMH services identified by clinicians were similar to those identified by team leaders and included a perception of **insufficient resources** devoted to child and youth mental health, **lengthy waitlists** and service demands that exceed capacity, **limited access to residential services**, the relative Ministry **emphasis on child protection** versus CYMH, and frustration over the time requirements and **problems associated with CARIS implementation**.

APPENDIX 6

**“Dealing with Depression” booklet distribution**

<b>MONTH</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>	<b>2005</b>
<b>January</b>	759	324	110	
<b>February</b>	456	615	465	
<b>March</b>	692	239	186	
<b>April</b>	1,237	401	35	
<b>May</b>		156	111	4,214
<b>June</b>		406	100	1,100
<b>July</b>		5	309	250
<b>August</b>		427	242	255
<b>September</b>		837	308	389
<b>October</b>		276	462	1,011
<b>November</b>		813	935	951
<b>December</b>		587	481	200

**TOTALS:            3,144            5,086            3,744            8,370**

## Summary of staff training to March 31, 2008

PROVINCIAL CYMH STAFF TRAINING at End of March 2008																
Level 1: Core Essential																
	Orientation	CARIS	BCFPI	Aboriginal Cultural Sensitivity Training	Suicide Intervention	CBT	Advanced DSM	Clinical Supervision								
<b>Course Status</b>																
Complete [C]	305	430	397	227	147	405	265	73								
# done ext. [C*]	21	0	0	1	16	10	3	0								
In Progress [IP]	3	7	10	25	15	10	10	13								
Required [R]	42	14	33	122	155	43	119	55								
<b>% Complete or In Progress</b>	<b>89%</b>	<b>97%</b>	<b>93%</b>	<b>67%</b>	<b>53%</b>	<b>91%</b>	<b>70%</b>	<b>61%</b>								
Level 2: Core Targeted																
	DBT Introduction	DBT Intensive	Infant Mental Health 1	Infant Mental Health 2	Infant Mental Health 3	IPT Introduction	IPT Intensive	Trauma Focused CBT (General)	Trauma Focused CBT (SAIP)	Dual Diagnosis	Concurrent Disorders	Eating Disorders	CBT Certification	DBT Consultation	IPT Consultation	
<b>Course Status</b>																
Complete [C]	83	42	72	54	53	75	30	16	19	59	26	106	7	129	22	7
# done ext. [C*]	6	1	3	3	3	0	0	3	5	5	11	4	5	1	0	0
In Progress [IP]	64	3	9	1	1	14	9	1	10	18	11	19	7	71	15	9
Required [R]	27	52	48	46	46	69	47	138	42	97	89	41	68	45	35	30
<b>% Complete or In Progress</b>	<b>85%</b>	<b>47%</b>	<b>64%</b>	<b>56%</b>	<b>55%</b>	<b>56%</b>	<b>45%</b>	<b>13%</b>	<b>45%</b>	<b>46%</b>	<b>35%</b>	<b>76%</b>	<b>22%</b>	<b>82%</b>	<b>51%</b>	<b>35%</b>

## Building collaborative networks to support CYMH in BC

### WHAT ARE CRITICAL SUCCESS FACTORS FOR DEVELOPING ORGANIZATIONAL NETWORKS?

In recent years, researchers have studied many different networks in a broad range of settings. Based on the research tentative conclusions can be drawn about what effective networks look like. This list is not exhaustive, but provides a brief overview of much of what is known about organizational networks.

- **Multiple levels of collaboration.** Collaboration should occur at multiple organizational levels. Having network ties at only one organizational level; for instance, only through top-level administrators, minimizes commitment to the network by lower-level organizational participants, thus reducing the chances of successful implementation of network strategies. Involving multiple people in an organization also increases the likelihood that network links will be maintained if someone leaves the organization.
- **Focused integration.** Extremely dense networks are inefficient, requiring a great deal of time and energy to maintain. Effective networks should have moderate levels of integration among members, with some fragmentation and structural holes.
- **Link strength.** The strength of linkages among network members should be varied, depending on critical network needs. Some organizations should be connected through multiple ties, but weak ties can and should be maintained to other network members.
- **Network governance.** Governance of the network should be based on the size and complexity of the network as well as on its stage of evolution. Generally, while small networks can be self-governed, larger networks are most effective when governed through a lead agency or network administrative organization.
- **Involvement.** Most network relationships should be based on trust and commitment to network goals, even when contractual ties (funding, etc.) are present. Trust and commitment generally need to be built gradually, often first through low-intensity ties.
- **Legitimacy.** Networks must build legitimacy as they grow. This can be done both internally (through network members) and externally (through outside funders, the media, etc.). Legitimacy helps to build commitment to the network and its goals and is critical for sustaining the network.
- **Resources.** Effective networks have sufficient resources to work on network-level goals and activities, rather than focusing solely on internal organizational issues. Resources can come from network members or from outside sources. Minimally, resources are needed for staffing, phones, newsletters, and the like.
- **Goals.** While long-term goals, like improved health status, are important, results are often not apparent for many years. Thus, networks must have goals that are specific, attainable, and appealing to a broad range of network members. To build commitment and legitimacy, network members must feel they are actually accomplishing something. Such goals can focus on network structure, processes, and short-range outcomes.

- **Stability.** Although networks are designed for flexibility, major system upheavals are not conducive to network effectiveness, especially after early formation and growth. Major system change can be disruptive to established, trust-based relationships that have evolved over a long period.

## **WHAT IS THE VALUE OF ORGANIZATIONAL NETWORKS?**

The growth of cooperative networks of organizations has become a key strategy for addressing the public's most pressing health and human services needs. They have become important mechanisms in many states and communities, as well as nationally and even internationally, for:

- Building capacity to recognize complex health and social problems,
- Systematically planning for how such problems might best be addressed,
- Developing and implementing policy around these problems,
- Mobilizing, leveraging, and attaining scarce resources,
- Facilitating the flow of knowledge and information to address complex problems, and
- Delivering needed services.

By working together as a network, organizations can improve both their efficiency and the effectiveness of the services and programs they offer. Potential benefits of network involvement are substantial, and include improved services, better access to these services for clients, less duplication of effort, better communication and access to needed information, improved innovation, and ultimately, improved health status indicators. Networks have been shown to be especially valuable for nonprofit and public organizations working to address a broad range of problems in community and regional health and human services because they can:

- Provide a team approach to complex public health issues,
- Address multiple needs,
- Counteract the fragmentation of multiple provider organizations,
- Ease problems related to geographic dispersion,
- Naturally optimize the use of resources, and
- Help transfer knowledge and enhance learning.

## **WHAT ARE THE POTENTIAL PROBLEMS WITH ORGANIZATIONAL NETWORKS?**

Of course, networks also have shortcomings, which can seriously undermine their effectiveness, even resulting in dissolution. There are numerous challenges to building and maintaining a successful network, but several factors stand out as being most common, based on the research that has been conducted to date.

- **They can undermine decision autonomy.** The downside of collaboration in any setting is that participants can no longer focus on their own specific needs. In organizational networks, members must consider the interests and expectations of other network members, thereby limiting their own decision autonomy. The problem is most acute for those network members that cooperate especially closely since decisions made by one will have a major impact on the other.
- **They can generate conflicting loyalty and commitment.** Even in organizational networks, the key links are among individuals. These individuals are employed by, trained by, and socialized in one particular organization. Network involvement means going beyond the employing organization - in effect, becoming a multi-organizational participant. Often, however, loyalty and commitment to the organization are stronger than to the network, even though organizational goals may best be accomplished through network collaboration.
- **They require additional time and resources.** Although one of the main benefits of networks is that they can overcome system-wide resource deficiencies, they do require resources to establish and operate. These resources may come from external sources, such as government agencies or foundations, or they may consist of contributions from network members. In either case, however, network members may feel that these resources are ones that could best be spent on their own organization and its clients. This problem is especially true when considering the contribution of time to participate in maintaining the network and its management. Directors of health and human service agencies generally embrace the network concept, but not necessarily the time, effort, and money it takes to build and maintain an effective network.
- **They require managing collaboratively rather than hierarchically.** Although traditional bureaucratic forms of control may not be widely accepted in most health and human service settings, organizational employees still work in hierarchical settings governed by rules, procedures, and the decisions of supervisors and top management. This mechanism is efficient and well understood. In contrast, networks have no hierarchy. While some organizational members may clearly be more influential than others, none has the right to give orders. As a result, network decisions can be messy, time-consuming, and often frustrating, especially to those who are accustomed to working in a hierarchy. Some networks are only designed to share information, limiting this problem. However, many others are designed to coordinate delivery of services and programs, requiring significant agreement from participants. While network decisions need not necessarily be consensual, they do need to be based on trust and reciprocity if the network is to be successful over an extended period.

While these shortcomings are very real and can limit what networks can accomplish, most health and human services professionals recognize the advantages of networks, at least in a general way, and believe strongly in the value of the collaborative process.

This Appendix is drawn directly from the work of Dr. Keith Provan in Trochim W, Best A, Clark P, & Leischow S. (Eds.). (2007) *Transforming Tobacco Control through Systems Thinking: Integrating Research and Practice to Improve Outcomes*. Smoking and Tobacco Control Monograph. Bethesda, MD: U.S. National Cancer Institute.

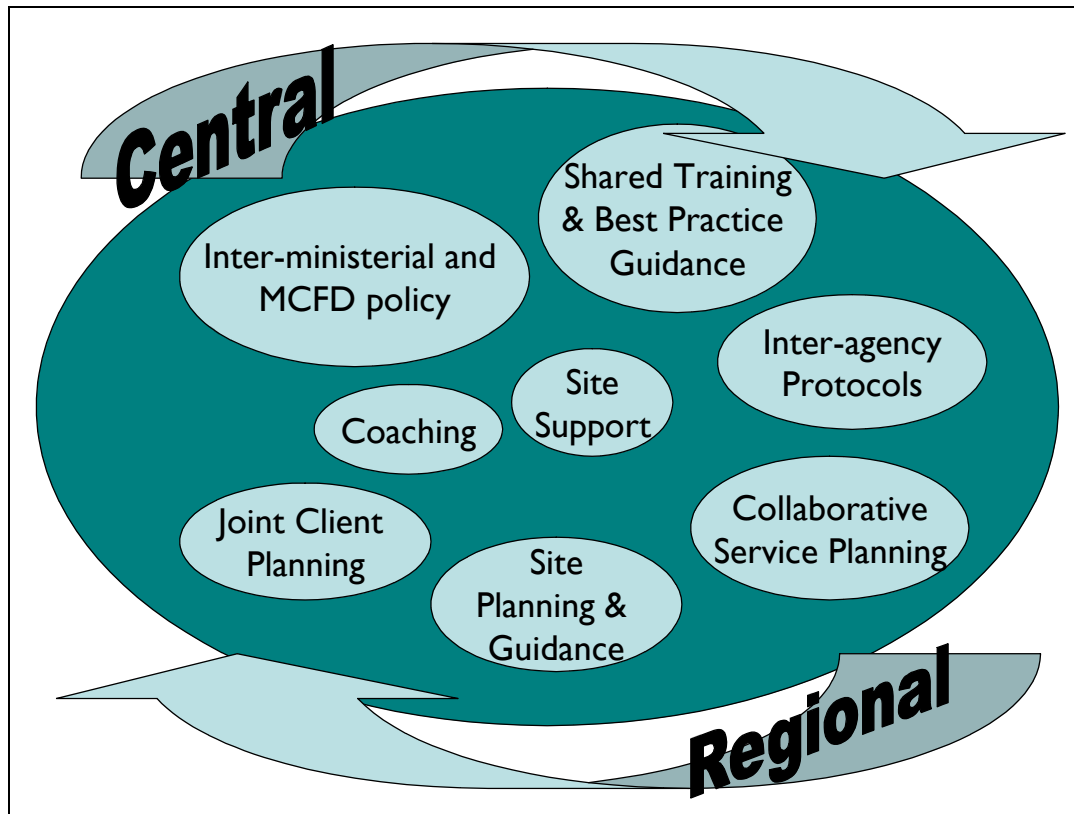
## **“The Active Ingredients” - factors proven to improve service coordination and build system capacity**

The Strong, Safe and Supported action plan emphasizes enhanced co-ordination and cross-ministry work to transform service delivery. Among other critical factors, this requires changing the way services are delivered. Simpson et al. (2001) note the “growing emphasis in service delivery on trans-disciplinary and trans-agency collaboration so that child-serving agencies can best meet the needs of children and their families” (p.15). This was of course a major thrust for the CYMH Plan also. Because many different clinicians serve families of children with CYMH issues (e.g. MCFD staff, GPs, private clinicians, school and HA staff), coordination is essential.

In implementing such an approach, however, we need to look beyond generalized good intentions to specific, practical actions. It is beyond the scope of this report to review the literature on large-scale organizational change in the field of social care. Fortunately, recent work in BC to improve chronic illness care offers some common-sense parallels to consider. Moreover, several key enabling factors have been shown to support coordination. A meta-analysis of studies by McDonald et al. (2007) identified the following “active ingredients”:

1. Information systems (addressed in Appendix 10)
2. Tools (protocols or guidelines, provider education, discussed in main body of this report)
3. Interface techniques (case coordinators or client navigators, multidisciplinary teams, collaborative practice models, discussed below)
4. System redesign (discussed in main report and below)

FIGURE A-1 DIFFERENT METHODS FOR SUPPORTING NEW WAYS OF WORKING



## WHAT DOES CAPACITY BUILDING LOOK LIKE?

### EVIDENCE-BASED GUIDELINES AND JOINT PROTOCOLS

The use of evidence-based guidelines and joint protocols to support the management of chronic conditions and amongst multidisciplinary teams is **well documented in the literature**.

Guidelines often include:

- Treatment plan
- Client and family education
- Recommendations for scheduled follow-up rather than waiting for problems to arise
- How to monitor outcomes
- Recommendations for when to refer for specialist consultation

BC's Expanded Chronic Illness Care Model (Barr 2003) highlights the use of **evidence-based guidelines and standard protocols within a community-based health promotion context**. Globally, the evidence shows care coordination models using structured protocols and active



follow up have produced beneficial effects for a range of chronic conditions, including mental health issues (Aubert et al. 1998).

## **EDUCATING CLINICIANS IN COORDINATION SKILLS**

For collaborative models of care to function effectively, clinical education, whether in the form of continuing professional development or at the undergraduate level, needs to support the modeling of a team approach. Education is critical as many clinicians, especially physicians have traditionally worked in isolation and are unfamiliar with the elements involved in working collaboratively (Rothman and Wagner 2003).

In BC, the College of Health Disciplines at the University of British Columbia (UBC) is leading the way in interprofessional health education and research. **UBC's program trains students across health and social service disciplines** with the aim to improve the way professionals collaborate. This may be an area worth exploring with other academic programs offering education in social services.

Following on a variety of evidence-based practice changes in the UK, policy-makers identified a similar need for effective team working (United Kingdom 2008).

([http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_074501](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074501)). The Creating Capable Teams Approach that they developed is an 'off the shelf' product that can be delivered by any experienced facilitator. It aims to help redesign services at a multidisciplinary team level, including methods to review their skill mix and refine their learning and development needs based on service user needs. This approach or something similar could be used with MCFD-only sessions or could include the wider community of service providers.

## **COLLABORATIVE PRACTICE CONNECTS COMMUNITY AGENCIES WITH SPECIALIST RESOURCES**

Transitions between care settings, especially between community (including GPs) and specialty services, are challenging and often fraught with mishaps. It is at **the point of hand-off where the majority of problems arise** such as poor information exchange or uncoordinated transitions. Collaborative practice models can connect different settings or levels of service, ensuring consistent quality, timely access and better communication.

In collaborative practice models, front line staff act as more than just a gatekeeper to specialty care. Information is more readily shared so **clients and providers both experience better** continuity. **Coordinated care agreements** between GPs, specialists and community agencies services have been shown to enhance collaboration and improve patient care delivery. In Australia, GP's, psychiatrists and staff from community mental health programs use regular contact and a collaborative care agreement to share care (Keks et al, 1997). **The agreement outlines how care is jointly managed between providers.** It includes medication protocols, interventions available from community services, rehabilitation needs, frequency of monitoring

by the case manager and a plan for crisis management including what level of care (primary or specialty) is required during specific situations.

The idea of “**stepped care**” is a specific shared care approach that supports the community team’s primary role with clients suffering chronic illness (Von Korff and Tiemens 2000). According to a UK study, clients suffering chronic mental illness received more coordinated and multidisciplinary care based on careful articulation of roles, referral thresholds, pathways and client self-management (Bower and Gilbody 2005).

## **CASE COORDINATORS OR “NAVIGATORS”**

Case coordination or navigation typically involves a single person who coordinates all aspects of an individual’s care. The coordinator provides information to multiple providers, ensuring the client receives care in a timely manner and coordinating all aspects of service delivery. Payne et al. (2002) found that **using a coordinator to facilitate the transfer of information** improved the quality of information provided; improved client and provider satisfaction; and increased client adherence to recommended treatment. The meta-analysis of studies by McDonald et al. (2007) on case management for patients with mental health issues, heart failure and diabetes showed improved outcomes.

**Navigation is similar to case coordination with a particular focus on reducing barriers to service.** Navigation has been found to improve a provider’s ability to engage, track and support clients and to develop communication and trust between a clinic and disadvantaged populations (Dohan and Schrag 2005). However, a review of case management literature concludes that while there is **general agreement on the common components of case management** models (outreach, screening and intake, assessing, care planning, arranging service, monitoring and reassessing) these components are **implemented with considerable variation** (Dohan and Schrag 2005). These variations are often due to factors such as the location from which the case management is provided, the type of case manager and level of authority and the purposes of the services being provided.

## **REDESIGNING THE REFERRAL AND REPORTING PROCESS**

Most observers agree that the process by which clients are referred could be improved: is evidence that patients may be referred to a specialist inappropriately, not referred when they should have been, or have unnecessary tests or procedures when being referred. A Cochrane Review (Grimshaw et al, 2005) explored the question, “Are there effective methods to improve the process of referring patients to specialized care?” The authors concluded that **active local educational interventions involving secondary care specialists and structured referral sheets** are the only interventions shown to impact on referral rates. Generally, effective strategies included dissemination of guidelines with structured referral sheets and involvement of consultants in educational activities.

## ISSUES TO CONSIDER WHEN DEVELOPING COLLABORATIVE INITIATIVES

### 1. Defining the work

- a. How would the goals be defined in this project?
- b. How will you define collaboration and coordination for purposes of implementation and evaluation?
- c. How do various members of your team (e.g., CYMH clinicians, family physicians, educators and social workers) understand collaboration and coordination? What are the similarities and differences in their points of view?

### 2. Structuring the coordination of services in your project.

- a. What would optimal service coordination look like for your situation today?
- b. What systems are needed for coordination to be most effective?
- c. How would you expect to increase client access through your project?
- d. How will you select people for the coordination training provided by this project? What is the ideal background, skill set and caseload?
- e. What is the role of information technology in your project?
- f. Are any financial incentives needed for providers or clients (e.g. travel support)?

### 3. Coordination settings.

- a. Where in the service continuum between general community programs and specialist services is coordination most likely to break down?
- b. How will your project improve coordination across settings?
- c. Which types of client groups would benefit most from your project?
- d. Which client groups are most likely to have poor coordination experiences?
- e. How does coordination vary by condition, ethnicity and/or age of the population?

### 4. Provider and client roles.

- a. How do you envisage the client and family roles in your project?
- b. How will coordination differ according to the service provider's role? Is what a GP does to promote coordination different from what a CYMH clinician or community health nurse does?
- c. What is the best provider skill mix to improve coordination in your project?

### 5. Assessing the impact.

- a. How should the process of coordination be measured in your project?
- b. How will you assess the cost of your project? How will you know if it is effective?
- c. What outcomes should be measured to ascertain if coordination is making a difference? Over what period?
- d. How will you determine if clients and families are more satisfied?
- e. Is your project expected to increase the timeliness of services? By how much?

## Improving Service Quality with Information and Communication Technology [ICT]

### WHY ICT?

ICT has the potential to enable a dramatic transformation in the delivery of services to CYMH clients (e.g. [http://gucchd.georgetown.edu/programs/ta\\_center/index.html](http://gucchd.georgetown.edu/programs/ta_center/index.html)). There are many claims for the benefits of ICT, which can be summarized within four areas:

1. **Improved quality** of service through integrated information over time and between settings :
  - a. provides decision support to front-line staff,
  - b. helps to improve practice (service reminders, streamlined information, reports)
  - c. encourages a consistent approach/standardization, and
  - d. allows easier assessment of the appropriateness and quality of care.
2. **Reduced cost** derives from:
  - a. automates tasks,
  - b. minimizes the likelihood of duplication or missed services,
  - c. reduces information going missing, increases the security of information, and
  - d. generally improves efficiency and saves space of paper records.
3. **Communication** improves due to:
  - b. better quality (legibility etc.) and access to client information,
  - c. faster access to results of consultation, and
  - d. more effective sharing of information among all members of the team.
4. **Analysis** is supported through:
  - a. tools for audit, evaluation and outcome assessment and research,
  - b. demonstrated clinical competence, (also a source of legal protection), and
  - c. trending of patterns in the well-being of individual clients and communities.

### CRITICAL SUCCESS FACTORS FOR IMPLEMENTING ICT SOLUTIONS

Why do so many ICT solutions fail to deliver the expected results? In a rare **documentation and analysis of ICT implementation failure**, staff from Kaiser Permanente (Scott et al, 2005) described the organization's experiences in implementing a Clinical Information System [CIS] in four primary care clinics and a hospital, serving 235,000 patients. After two difficult years of implementing one CIS product, a decision was made to shelve this project and start again with a different vendor. A costly, time consuming and challenging experience for all led to these conclusions:

- CIS initially clarified and then changed roles and responsibilities;

- Culture had varying effects: cooperative values minimized resistance to change early on but also inhibited feedback during implementation;
- Leadership had varying effects: participatory leadership was valued for selection decisions, but hierarchical leadership was valued for implementation;
- An overall effect was a counter climate of conflict, which withdrawal of the CIS resolved.

### The parallels with implementation of CARIS and to a lesser extent BCFPI are instructive.

Further analyzing the reasons for failure in implementing ICT systems, Winthereik and Bansler (2007) comment on the effort necessary to “incorporate a new technology into **the existing ‘information ecology’, i.e. the existing system of people, practices, terminologies, and information and communication technologies in the local environment.** Successful implementation is difficult to achieve, because information ecologies are diverse, continually evolving, and [interdependent]. For instance, communication media, documentation standards, incentive structures and local work practices are interrelated and fit together in complex and subtle ways.”<sup>1</sup> This ecological viewpoint reinforces the complex health care environment within which any changes occur and affect other elements. The ecological analogy is particularly useful. The other lesson from this study: **Proceed with caution.**

## THE ORGANIZATIONAL CONTEXT

Most thoughtful commentators about the role of ICT in improving service quality acknowledge the potential pitfalls and provide advice on navigating these. In particular, they recommend attending to the **impact on “boundaries” and “interfaces” as new infrastructures are created.** As noted elsewhere in this report organizational practices, roles and identities are the devilish details of organizational improvement. Changing any aspect of a complex system (such as the existing information ecology) is likely to affect other components of the system. In addition to technology specialists and clinical expertise, organizational behaviour expertise is needed. **An early priority should be determining the focus of the collaboration that the ICT is supposed to support:** is it sharing responsibility, improving decision-making, developing data sources for planning, or monitoring and evaluation? Deciding exactly which components will be part of the specific initiative is crucial.

From an organizational behaviour perspective, we can identify several **“lessons learned”** from the Kaiser Permanente experience noted previously:

- set and communicate clear objectives and formulate a strategic plan (and modify when necessary);
- work at achieving ownership of the plan by people at all levels;
- pay attention to the organizational culture and whether it supports the changes being implemented;

- develop leaders and champions for the change (not just those in traditional positions of power);
- be patient and resist false urgency;
- stay involved and keep communicating;
- evaluate;
- seek feedback (and act on it); and
- plan ahead for the next phase of change.

## The Discipline of Execution

*Abridged from Charan R (2008) <http://www.exhibitoronline.com/corpevent/article.asp?ID=840>*

**When companies fail to deliver** on their promises, the most frequent explanation is that the strategy was wrong. However, the strategy by itself is not often the cause. Strategies most often fail because they are not executed well — things that are supposed to happen do not happen.

Execution helps business leaders choose a more robust strategy. You can't craft a worthwhile strategy if you don't at the same time make sure your organization has or can get what's required to execute it, including the right resources and the right people. Execution is not just tactics — it is a discipline and a system. It has to be built into a company's strategy, its goals, and its culture.

The heart of execution lies in three core processes: the people process, the strategy process, and the operations process. Every business and company uses these processes in one form or other. But more often than not, they stand apart from one another like silos. People perform them by rote and as quickly as possible, so they can get back to their perceived work. The key to successful execution is linking people, strategy, and operations together.

### THE PEOPLE PROCESS

The people process is the most important of the three processes. After all, it is the people of an organization who make judgments about how markets are changing, create strategies based on those judgments, and translate the strategies into operational realities. To put it simply and starkly: If you do not get the people process right, you will never fulfill the potential of your business. The right people are in the right jobs when information about individuals is collected constantly and leaders know the people, how they work together, and whether they deliver results — or fail to. A robust people process does three things:

1. It evaluates individuals accurately and in depth.
2. It provides a framework for identifying and developing the leadership talent needed to execute strategies down the road.
3. It fills the leadership pipeline that is the basis of a strong succession plan.

### THE STRATEGY PROCESS

The basic goal of any strategy is simple enough: to define an organization's direction and position it to move in that direction. Why, then, do so many strategies fail? Few understand that a good strategic-planning process also requires the utmost attention to the "how" of executing the strategy. In creating it, you as a leader have to ask whether and how your organization can do the things that are needed to achieve its goals.

Developing such a plan starts with identifying and defining the critical issues behind the strategy. To be effective, a strategy has to be constructed and owned by those who will execute it. Staff people can help by collecting data and using analytical tools, but the leaders must be in charge of developing the

substance of the strategic plan.

Service leaders are in the best position to introduce new ideas, to know which will work in their region, to understand what new organizational capabilities may be needed, to weight risks, to evaluate alternatives, and to resolve critical issues that planning should address but too often doesn't. When guided by a leader who has a comprehensive understanding of the environment, all members of the group can be part of the robust dialogue that is central to the execution culture. Discussing the strategy creates excitement and alignment, and the energy that these discussions build strengthens the process.

The strategy also has to include specific milestones to bring reality to the plan. If the organization does not meet milestones as it executes the plan, leaders have to reconsider whether they have the right strategy after all. Periodic reviews can help you to understand what is happening and what turns in the road are necessary.

## **THE OPERATIONS PROCESS**

The strategy process defines where an organization wants to go, and the people process defines who is going to get it there. The operations process provides the path for those people. It breaks long-term output into short-term targets.

In the operating plan, the leader is primarily responsible for overseeing the seamless transition from strategy to operations. She has to set the goals, link the details of the operations process to the people and strategy processes, and lead the operating reviews that bring people together around the operating plan. She has to make timely judgments in the face of uncertainties. She has to conduct robust dialogue that surfaces truth. At the same time, the leader is learning — about her people, and how they behave, and about the pitfalls that beset elegant strategies.

Again, as with the strategy process, it is not just the leader alone who has to be present and involved. All of the people accountable for executing the plan need to help construct it.

Typically, operating plans are based on a budget that has been previously prepared. This is backward: the budget should be the financial expression of the operating plan, rather than the other way around. Budgets often have little to do with the reality of execution because they are numbers and gaming exercises. Instead, people spend months figuring out how to protect their interests rather than focusing on the company's critical issues. The financial targets are often no more than the increases from the previous year's results. The resulting rigid budget can lead to missed opportunities. An operating plan addresses the critical issues in execution by building the budget on realities.

The first step in building an operations plan is to debate the assumptions behind your goals; for example, who is the client? What is the need? What is the competition doing? Is your value proposition good enough? The next step is to build the operating plan itself. It's a three-part process:

1. Set the targets.
2. Develop the action plans and make the necessary trade-offs between short- and long-term goals.
3. Secure agreement and closure from all the participants, establishing follow-through measures to make sure people are meeting their commitments.

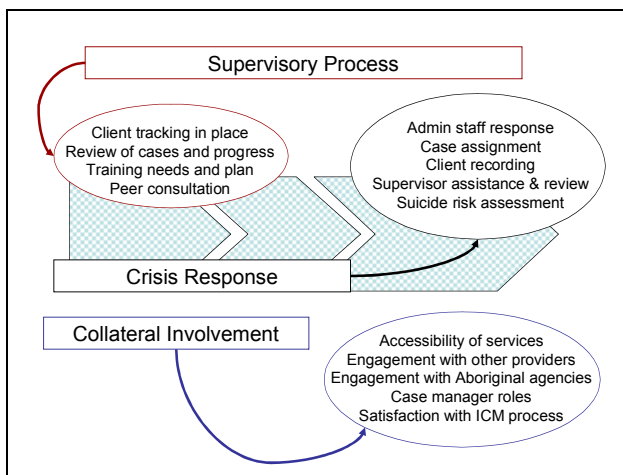
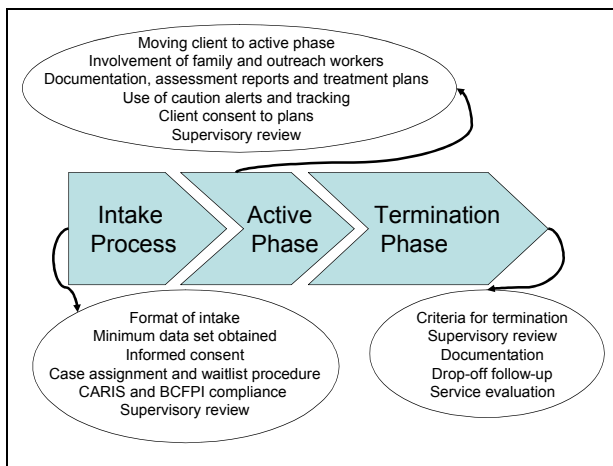
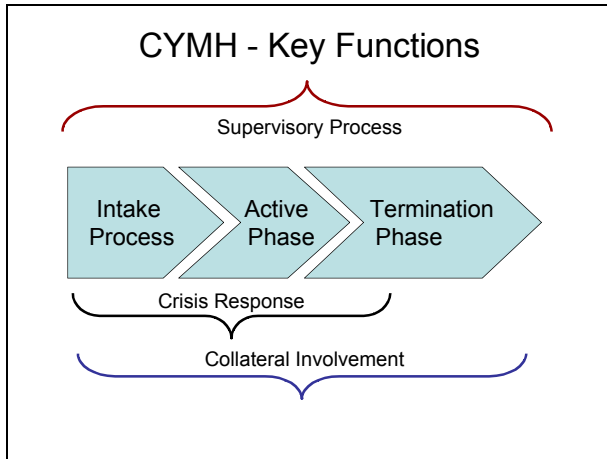
Finally, follow through with the operating plan, making sure all parties take accountability for what they have agreed to do, establishing contingency plans, and conducting quarterly reviews.



To have realism in your strategy you have to link it to your people process. Do you have the right people in place to execute the strategy? If not, how are you going to get them?

Then you have to link your strategic plan's specifics to your operating plan, so that the multiple moving parts of the organization are aligned to get you where you want to go. **The result is successful execution, and, ultimately, a successful organization.**

## Topics for process improvement



## Glossary of Terms

<b>A/CSM</b>	Acting Community Services Manager
<b>ACSIRT</b>	Aboriginal Community Suicide Intervention Response Team
<b>ADHD</b>	Attention Deficit Hyperactivity Disorder
<b>ADM</b>	Assistant Deputy Minister
<b>BCCH</b>	British Columbia Children’s Hospital
<b>BCFPI</b>	Brief Child and Family Phone Interview
<b>BSW</b>	Bachelor of Social Work
<b>CARIS</b>	Community and Residential Information System
<b>CBT</b>	Cognitive Behavioral Therapy
<b>CF&amp;CS</b>	Child, Family and Community Services
<b>CYMH Network (aka <i>The Network</i>)</b>	Advisory committee made up of representatives from MCFD, MoHS, Med and community stakeholders
<b>CIS</b>	Clinical Information System, e.g. CARIS
<b>Concurrent Disorders</b>	Co-occurrence of mental health and substance abuse disorders
<b>CSM</b>	Community Services Manager
<b>CYMH</b>	Child and Youth Mental Health
<b>CYMH Stakeholders</b>	A broad range of individuals involved with and/or interested in the system of children’s mental health services including government and non-government health and social service providers, advocacy groups, families, researchers, academics, and community members
<b>CYMH PAC</b>	CYMH Policy Advisory Committee
<b>CYSN</b>	Child and Youth with Special Needs
<b>DBT</b>	Dialectical Behavioral Therapy
<b>DIP</b>	Director of Integrated Practice
<b>DSM</b>	Diagnostic and Statistical Manual, a manual for classification and diagnosis of mental disorders

<b>Dual Diagnosis</b>	Co-occurrence of developmental disability and mental illness
<b>ECD</b>	Early Childhood development
<b>EPI</b>	Early Psychosis Intervention initiative
<b>External Advisory Committee</b>	Provincial advisory committee that supported the implementation of the CYMH Plan chaired by the Minister, MCFD
<b>FASD</b>	Fetal alcohol spectrum disorder
<b>FNSA</b>	First Nations Schools Association
<b>FRIENDS</b>	A school-based anxiety prevention and resiliency building program
<b>The Five Pillars</b>	The key elements of the cross-government Strong, Safe and Supported Framework, led by MCFD: Prevention, Early Intervention, Intervention and Support, The Aboriginal Approach, and Quality Assurance. <i>See also, Strong, Safe and Supported.</i>
<b>The FORCE</b>	Families Organized for Recognition and Care Equity. An advocacy and support group for parents who have children with mental health issues
<b>GP</b>	General practitioner, physician
<b>HA</b>	Health Authority
<b>HR</b>	Human Resources
<b>ICT</b>	Information and Communication Technology
<b>IM/IT</b>	Information Management/Information Technology
<b>IPT</b>	Interpersonal Psychotherapy
<b>MCFD</b>	Ministry of Children and Family Development
<b>MEd</b>	Ministry of Education
<b>MHLS</b>	Ministry of Healthy Living and Sport
<b>MoHS</b>	Ministry of Health Services
<b>NH</b>	Northern Health

<b>PGRH</b>	Prince George Regional Hospital
<b>PHSA</b>	Provincial Health Services Authority
<b>Plan, or the CYMH Plan</b>	The five-year Child and Youth Mental Health Plan for British Columbia
<b>RASM</b>	Regional Aboriginal Service Manager
<b>RED</b>	Regional Executive Director
<b>RFP</b>	Request for Proposal
<b>RMC</b>	Regional Child and Youth Mental Health Manager or Consultant
<b>Safe Houses</b>	Typically shelters for street youth, also sometimes offer basic mental/general health services
<b>SAIP</b>	Sexual Abuse Intervention Program
<b>SCIP</b>	Small Community Intervention Program
<b>SD</b>	School District
<b>SFU</b>	Simon Fraser University
<b>SIL</b>	Supported Independent Living programs
<b>“Step up” &amp; “Step Down” Facilities</b>	Therapeutic residential programs that support children or youth who need intensive support during transitions between community-based programs and hospital care
<b>Strong, Safe and Supported Framework</b>	A cross-government framework led by MCFD to support an effective child, youth and family development service system in BC. <i>See also, The Five Pillars.</i>
<b>Ten-Year Mental Health and Substance Use Plan</b>	10-year plan that is being proposed to support improvements to mental health and addictions services across the lifespan, led by MoHS and MHLS
<b>UNBC</b>	University of British Columbia