The State of Child and Youth Mental Health in Canada:

Past Problems and Future Fantasies

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Berezin (1978), a geriatric psychiatrist from Harvard, says that as we get older, our personality does not change, it just gets more so! How can it be then, that in 2010, despite the best efforts of many, the state of child and youth mental health in Canada is unknown to countless people? How can it be that despite the fact that nothing has changed for years, except to get *more so*, few know about the plight of Canadian child and youth mental health services? How can it be that in Ontario, politicians, regardless of political party (all parties have been in power at some time during the past 20 years), have known the facts about child and youth mental health and have effectively turned a blind eye?

It is a shameful state of affairs that makes one wonder how much our society really cares about the well-being of our children and youth. There is too much meaningless rhetoric, especially from politicians: "Our children and youth are our future!" This is talk that has never been walked. And, yet, if we were to make the relatively modest financial investments required to ensure that the physical and mental health of our children and youth were as good as possible, we would have a much better chance of maximizing their potential, of reducing stress in their lives and their families, of optimizing their life trajectory, of improving the calibre of the workforce in Canada and, ultimately, of improving the physical and mental health among the Canadian population as a whole. It makes imminent good sense; yet, our leaders continue to turn a blind eye! Perhaps it is because improving the health of our children and youth will take many years, whereas politicians often focus on their brief tenure and securing their next term of office. As well, children and youth simply do not have a vote.

Recently, in Ontario, there has been a considerable focus on mental health and addictions across the lifespan. Essentially, there are two initiatives simultaneously under way (not necessarily matching up, although the recommendations are similar in several areas). The first derives from the recently released report of the Select Committee on Mental Health and Addictions (Legislative Assembly of Ontario 2010). This committee is made up of members of all political parties. In essence, the committee endorses what many of us have said for years. There is no system of mental health services across the lifespan in Ontario; the committee recommends that all mental health services (including child and youth services) be funded out of the Ontario Ministry of Health and Long-Term Care (MOHLTC) and that there be an overarching agency similar to Cancer Care Ontario to implement the mental health strategy for the province. The mission for the proposed Mental Health and Addictions Ontario is to reduce the burden of mental illness and addictions by ensuring that all Ontario residents have timely and equitable access to an integrated system of excellent, coordinated and efficient promotion, prevention, early intervention, treatment and community support programs. MOHLTC has simultaneously been working on a 10-year mental health addictions strategy titled Every Door

is the Right Door. This report has not yet been released but has many similarities to the report from the Special Committee. However, a major difference involves the proposed governance structure – the 10-year strategy recommends that a committee made up of several ministries oversee the implementation of the mental health strategy.

Current State of Child and Youth Mental Health in Canada

So, what is the state of child and youth mental health in Canada today? Let's use Ontario as a lens through which to exemplify past problems in service delivery.

Proportion of Children and Youth Receiving Help

In Canada, it is estimated that between 14% (Waddell et al. 2002) and 25% (Health Canada 2002) of children and youth suffer from at least one diagnosable mental illness. The vast majority, however, are undiagnosed. The Ontario Child Health Study (Offord et al. 1987) found that 18.1% of four- to 16-year-olds had experienced at least one of four diagnosable mental illnesses in the previous six months. It can also be argued that mental disorders as a group constitute the largest burden of disease globally (World Health Organization 2001). These illnesses are all characterized by substantial morbidity, mortality (suicide is the leading cause of death among children and youth, after accidental death) and negative economic impact. Offord et al. (1987) estimated that only one in six children and youth (four to 16 years of age) with a diagnosable mental illness had received any intervention in the previous six months. (These data are 28 years old, and new data are required.)

Consider adults requiring hip or knee replacement. If services for this population were the same as they are for children and youth with mental health problems and only one in six adults requiring a hip or knee replacement received one, would our Canadian society tolerate or accept this situation? I suggest that in such a situation, governments would fall. It should be no different for our children and youth suffering with mental illness. In fact, their services should be a greater priority since the impairment to their life functioning and the compromising of their future life trajectories are much greater and over their lifetime will cost our society much more.

Early Identification and Intervention

Early identification and proper diagnosis and mental health treatments have been demonstrated to be effective in young people in both primary and specialty care settings alike. Such timely interventions can decrease disability, improve economic activity, enhance quality of life and reduce mortality (Kutcher and Davidson 2007). Yet help is frequently sought late for a range of reasons, including parents not recognizing mental health problems, professionals failing to identify troubles and the family-based stigma associated with having a mental disorder. Many families have reported that the stigma of mental illness is worse than the illness itself. They have also found that navigating available mental health services is enormously challenging.

Wait times are long. Some wait times, for example, for dual diagnosis problems that include autistic spectrum disorder together with other mental illnesses, can be as long as two years. For more acute problems, wait times may be somewhat shorter. However we look at the wait times issue, children and youth who have to wait for help run the risk of losing at least one school year, falling behind their peer group and incurring iatrogenically induced impaired functioning that goes even deeper than the impaired functioning associated with their original disorder. It is estimated that 70% of children and youth mental health problems can be solved through early diagnosis and interventions (Leitch 2007).

Continuity of Care

The fit (therapeutic alliance) between a young person and family/caregivers and a therapist is fundamental to any form of assessment or intervention (Cheng 2007). In such situations, transitioning youth into adult mental health services can become a substantial problem. Why should young people who are doing well in therapy transfer to adult mental health services simply because they have reached a certain chronological age? This transition is done very poorly in Canada in comparison to some other countries, most notably the United Kingdom and Australia.

Also, because child and youth mental health services are under-resourced, we are not able to offer families a full continuum of mental health services. Such a continuum should include health and wellness promotion and also illness prevention services. Yet, in most programs, less than 10% and in all likelihood less than 5% of the operating budget addresses this end of the continuum.

Potential Cost Savings

Over two-thirds of mental illnesses have their onset prior to age 25, and these are mostly chronic disorders that have a substantial impact on multiple personal, interpersonal, social and physical health domains (Kessler et al. 2005). Therefore, if such a majority of mental illnesses and addictions have their onset in childhood and adolescence, facilitating early identification and intervention to yield the best possible outcomes would make good sense. The relatively modest investment required will yield far better outcomes, create a healthier workforce and likely cost less over time.

Fragmentation

Romanow describes Canadian mental health services across the lifespan as the "orphan child of health care" (2002). It is therefore fitting that Kirby often refers to child and youth

mental healthcare services as "the orphan of the orphan." It is outrageous that in 2011, child and youth mental health services continue to be significantly less resourced than physical health services and seriously fragmented at all levels. There are ongoing tensions between the ministries that fund child and youth mental health services (although it must be recognized that over the past year communication between ministries, at least in Ontario, has improved). Tensions also exist between community- and hospital-based mental health services, as well as between sectors and between service providers of different disciplines. These factors potentiate the fragmentation.

In addition, the many disciplines that provide child and youth mental health services are generally trained in silos. Upon graduation, it is magically expected that these professionals will know how to work effectively within multidisciplinary teams with very little preparation and training. Given that there is considerable overlap in the work of the different disciplines, would it not be more effective to train all of these students together in the areas of overlap and in learning formally about how to function in multidisciplinary teams? For their particular area of expertise, they could get their training separately.

Best Practices and Benchmarks

So how do we ensure that those who manage to wait and access child and youth mental health services actually get the service that they need? Do these families know their rights? Are they offered explanations around all of their options for intervention? In the field of child and adolescent mental health, evidence-informed practices are not yet the rule of the day. Best practices in knowledge translation and dissemination in child and youth mental health are not well established.

Finally, it is surprising that we do not have any well-established benchmarks around expectations of the professionals who are hired to work in child and youth mental health. Across Ontario, we do not even know what the ratio should be between direct and indirect clinical service per mental health professional per 37.5-hour work week. As speculative as this example is, if the current standing were 15 hours of direct service and 22.5 hours of indirect service, and through legitimate efficiencies that did not compromise indirect care we could reverse the direct and indirect ratios in this example, without costing government a cent, direct service provision in Ontario could increase by 50%!

Where Do We Go from Here?

In Ontario, this unacceptable model of child and youth mental health service delivery dates back more than 30 years. The funding of child and youth mental health services, predominantly in the community, was shifted from the Ministry of Health to the then Ministry of Community and Social Services and its subsequent iterations and now the Ministry of Child and Youth Services. Regardless of the funding source, child and youth mental health services have not emerged as the critical priority they should be. Since 1992 there have only been two base funding increases for child and youth mental health service agencies funded by the Ministry of Child and Youth Services. These occurred in 2003 (3%) and 2006 (5%) (Auditor General of Ontario 2008: 125). Because more than 85% of operating budgets are allocated to human resource salaries and benefits within child and youth mental health services, the lack of annualized increases translates into service reductions, even longer wait times and poorer outcomes for children, youth, families and caregivers facing mental health challenges. Categorically, it is true that over the same time period, agencies funded by MOHLTC have received increased funding each and every year. How can our provincial decision-makers justify the serious inequity between service provision addressing physical illnesses of our children and youth and provisions addressing their serious mental health needs? Is it simply a 30-year oversight because child and youth mental health services are predominantly not funded by MOHLTC and are therefore forgotten? Leitch (2007) identifies the need to improve mental health services to Canadian children and youth as one of five specific priority recommendations.

Ironically, within this desert of child and youth mental health services, there are pockets of excellence and reasons for optimism! There are several innovative child and youth mental health programs and research studies across Canada, many of which remain best kept secrets due to inadequate knowledge mobilization strategies. It is beyond the scope of this article to mention them, for fear of omitting some.

The Mental Health Commission of Canada has prioritized child and youth mental health, and there are several funded initiatives under way. Within the National Strategy priority of the Commission, there are two child and youth initiatives. The Evergreen framework is complete and approved and due for release in the next few months. This non-prescriptive document, with national and international consensus, contains all of the ingredients for governments to consider when developing a child and youth policy framework that meets their particular needs and fiscal realities. The second initiative entails developing a comprehensive compendium of national and international best practices in school-based mental health and addictions services.

Within the Opening Minds anti-stigma, anti-discrimination priority area, the commission has prioritized working with youth and healthcare providers (including mental healthcare providers) to reduce stigma and discrimination. Within this area, the Child and Youth Advisory Committee has a family unit self-stigma initiative goal directed toward children and youth with lived mental illness experience and their siblings and parents. The hope is that a better understanding of mental illness will lead to stigma-reducing interventions for these families, permitting them to feel supported in society and be more willing to seek help early. There is also a knowledge mobilization initiative in

child and youth mental health within the commission's knowledge exchange priority area. The goal is to find best practices for use in creating comprehensive, credible, easily available child and youth mental health information for all stakeholders. Finally, and proudly, we have a Youth Council at the commission. Its purpose is to ensure that the youth voice is well heard and that the commission can get the youth viewpoint on all matters, products and projects under consideration. There are several other initiatives being explored. These include, but are not limited to, the development of universal parenting programs; First Nations, Inuit and Metis child and youth mental health pilot projects; and a national epidemiological child and youth mental health survey with ongoing longitudinal surveillance.

Also on a positive note, there is increasing awareness across Canada about the importance of mental well-being and of creating systems of care to address this as well as mental illness. The recent development of the Institute of Families brings further promise. Its vision is that families flourish as a result of being valued and engaged as integral partners in child and youth mental health.

In some of the provinces and territories, there is a serious interest in developing or renewing mental health frameworks and implementing them. Some jurisdictions, including Ontario, now also have child and youth mental health policy frameworks. While it is not infrequent that child and youth mental health services be funded by several different ministries, at least in recent times there is better communication between the ministries. This trend notwithstanding, in my opinion, all child and youth mental health services would be better served by being funded out of only one ministry.

The creation of the Ontario Centre of Excellence for Child and Youth Mental Health, seven years ago has been favourably received. The centre underscores the importance of child and youth mental health and makes new resources accessible to agencies. The major foci involve agencies increasing the use of evidence-informed practices, honing evaluation techniques, building local and provincial partnerships of care and fostering the existence of service agencies as learning organizations within the child and youth mental health sector.

In some more localized communities, often through necessity due to impoverished services and sometimes based on smart proactive planning, there are collaborations and even integrations. Such contemporary approaches allow the focus to be where it should, on what is in the best interests of the children and youth we are attempting to serve. A wonderful consequence is the reduction of territoriality and competition between agencies and sectors.

I suggest that the landscape outlined for Ontario is similar to or better than that of most other provinces and territories in Canada.

Hopes for the Future

Imagine that a province/territory decides to make the appropriate and modest investments in child and youth mental health. Imagine that this decision is non-partisan. It is prioritized, sustainable and ongoing for many years. Imagine that we have a system of child and youth mental health care that contains the following elements:

- Children and youth with lived mental health experience and their parents and caregivers are engaged and empowered in the establishment of not only their own individual healthcare plans but also the system of care that they desire and envision.
- Services are consumer driven and are provided to people in need at their preferred time and location (e.g., an agency or school – many youth prefer to not miss school when receiving their mental health care; several new school-based initiatives and interventions are outlined by Kutcher on p. 18).
- There is a shift from fragmentation to integration made up of a balanced, full continuum of services in which mental health, inclusive of universal programs, is an integral part. The importance of continuity of care is prioritized so that individuals and families with lived experience continue their care through key periods and transition into other services at appropriate junctions, rather than transfer to other services based on chronological age.
- Care is culturally safe and diversity oriented for all.
- Families assert their rights, and professionals discuss with them the full cadre of interventions that have proven efficacy. Families can choose their preferred intervention and all interventions, or at least the majority, are evidence-informed practices. (Kutcher elaborates on the use of best evidence on p. 17).
- There is adequate and sustainable funding to engage in contemporary research that guides the mental healthcare, informs the promotion and well-being of our children and youth and further develops evidence-informed practices to enhance outcomes (see Kutcher's discussion on p. 17).
- Knowledge is translated, disseminated and mobilized resulting in valid, reliable, comprehensive and available information for all stakeholders.
- Mental health professionals are trained in new and contemporary ways. Students of different disciplinary backgrounds are trained together in the areas of overlap and also in regard to how multidisciplinary teams work. These individuals are trained separately in regard to the specific expertise that they have and bring to the multidisciplinary team. (Kutcher further elaborates on this topic by discussing the shortfalls and changes needed in training of not just healthcare professionals but teachers too [p. 19].)

- Indirect services are made as efficient, effective and time limited as possible, recognizing the importance of team meetings, phone calls, paperwork and the like. Direct face-to-face assessment and intervention services are provided the majority of the time, and the benchmark for direct care and indirect care is well established, well monitored and well measured.
- The most contemporary approaches are used to measure outcomes and impact and to ensure that the system of care we are providing not only attains its goals but is also nimble, efficient and flexible and can be reoriented as necessary.

In conclusion, for years, not much in child and youth mental health data has changed, it has just become more so! Government, all political parties included, has turned a blind eye to the comprehensive mental health needs of our children and youth and their families and caregivers. What happened to the United Nations Rights of the Child, to which Canada is a signatory? What happened to substantiating political comments that "our children and youth are our future" with action? Ask our youth, and they will tell you that they are not just our future, they are our present! They are in fact the next generation of adults who will vote.

Transformational change in child and youth mental health is necessary. This includes substantial changes in the cadre of fragmented services that currently exist and entails the establishment of integrated communities of practice in child and youth mental health that we can proudly refer to as a system of care!

As well, more funding is essential. It is noteworthy that between 2010 and 2014, in the province of Ontario alone, signed contracts for federal transfer payments will increase by a cumulative total of $1.95 billion. It is time to right the inequities of the past and to be sensible in making the appropriate and modest investments in child and youth mental health that will, in the long run, lead to a much-enhanced Canadian fabric in which we have a more versatile, healthy and dynamic workforce and individuals who have a lower prevalence of mental illness.

As Kirby stated on various occasions, "It is time to bring mental health and mental illness out of the shadows forever." Mental health and mental illness begin with our children and youth. There are urgent and amazing opportunities to appropriately and thoughtfully transform child and youth mental health in Canada. To quote Tennessee Williams, "There is a time for departure even when there's no certain place to go." HQ

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