HEALTH SCIENCES ASSOCIATION
The union delivering modern health care

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Health Sciences Association of BC is the union delivering modern health care in BC's hospitals and communities. HSA represents hundreds of mental health care workers working across the province. HSA is pleased to make this submission to the BC Legislature's Select Standing Committee on Children and Youth.

It tells the story from the perspective of front line health science professionals working in that system.

Our members' expertise is in the delivery of the care they provide. HSA members are committed to their professions and to the service they provide to their patients, clients, and their families.

We thank the committee for your interest in the perspective of our members, and look forward to recommendations that are in the best interest of the patients, the people delivering the services, and the communities we all serve.

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Introduction

When BC's Representative for Children and Youth, Mary Ellen Turpel-Lafond, released the April 2013 Report*, Still Waiting: First-hand Experiences With Youth Mental Health Services in BC*, she put the important issues of mental health services and support for young people in the spotlight. What the spotlight revealed is a disjointed system that does not provide the services young people need. Her findings did not vary from the findings a decade old as outlined in the province's February 2003 *Child and Youth Mental Health Plan for British Columbia* .

Health Sciences Association (HSA) is a British Columbia union that represents health science professionals working in mental health and addictions in acute and community health care settings throughout the province. The union's members include child and youth mental health support workers, psychologists, counsellors, social workers, early childhood education specialists, registered psychiatric nurses, and a host of other health science professionals who work in the field. HSA members know first-hand the frustration children, youth, and their families encounter as they struggle with mental health disorders and substance and other addictions.

This submission to the BC Legislature's Select Standing Committee on Children and Youth examining youth mental health in BC reflects the experiences and perspectives of mental health specialists working to support children and youth who struggle with mental health and addictions – specialists who struggle every day to deliver support and services in a fractured system. The frustration expressed by these members over and over again is appropriately expressed in Ms. Turpel-Lafond's report by a physician: "The biggest frustration is the systemic disarray."

In spite of this frustration, mental health service providers continue to work to deliver the services their patients and clients need, and to identify areas of the system that can be improved to improve the experiences and outcomes for children, youth, and their families.

The Main Challenges: Gaps in Service

The Standing Committee asks four questions. The first two: "What are the main challenges around youth mental health in BC?" and "Are there current gaps in service delivery?" can be addressed as one.

The critical challenge in youth mental health is that there are gaps in service delivery. These gaps aren't just 'gaps': they are huge gaping holes lined up beside each other. In some cases, a small island of service may appear, but there are no bridges to the next complementary program or service – just more vast holes.

In March of this year, HSA held a Mental Health Forum in Vancouver to engage with the community about the services.

One of the presenters, an HSA member who works in mental health programs with adults, joined the panel to tell her story – as a health care provider and as a parent of a child who struggles with mental health and addictions issues. As a worker, the member was assaulted by a patient. She was forced off the job for several months. There were no proper violence prevention protocols in place, and the outcome for the patient suffered – as it did fundamentally for the worker trying to support her patients.

As a parent, she has spent the past several years advocating for support for her daughter, who started high school as a bright, athletic and involved student, but who quickly began to spiral out of control. In contact with the school, the family did not find support. The resources just were not available, and the easy out was to conclude that her child was just not trying hard enough, and that she was not interested in getting better.

“The joy of supporting her with her sporting and music events had been replaced by police visits, psychiatrist visits, family counselling… she was in and out of emergency. Then she would be released. No assessment. No information. Without any support. And zero follow-up.”

As a worker in mental health care she became an advocate for herself – to ensure anti-violence protocols were the norm and not the exception at her worksite. As a parent of a child involved in the mental health system she became an advocate for her child, navigating a complex, disjointed, confusing, and overwhelming system – made all the more challenging because of the intense emotional pressure on not just her child – but her whole family.

A youth mental health worker on Vancouver Island who has been in the field for 20 years describes the changes she has seen in her field.

“Up until the early 2000s, I was able to be a part of some progressive programs. There were dollars to do things. There was funding to create things like a one-bed placement that was therapeutic in nature. And then things shifted.

“In 2003, everything started getting cut. I would be cut from a job, then get a short-term contract to do work. There was no consistency for the kids or the services. You could no longer count on programs, or people, to be there to refer kids to.”

She now works in an alternative to custody program for 13- to 19-year-olds that serves the whole province. Operating under a community care home model, programming is provided during the day, with contracted care provided in community homes overnight. A majority of

the youth either have a formal mental health diagnosis or self-report mental health issues. Most are also substance involved.

To prepare for incoming youth, the program reaches out to their home community to assess the services the child may have been receiving and may require. Only about 10 per cent have had mental health support. Coming from all over the province, she sees the gaps in service for these children and youth.

For example, if a youth lives in Salmon Arm and the closest clinic is in Kamloops, chances are those with needs and limited resources and support are not going to travel for services. Once they do get to a walk-in clinic to try to get medication or treatment to deal with anxiety, sleep disorders, panic attacks, or any range of challenges including dual diagnoses, they may or may not get appropriate diagnosis, medication, or treatment – let alone the resources they need for after-care.

And when they go back home after six months or a year of intensive daily residential treatment, are they going to get the support and intervention in their home community?

So much of all youth mental health workers' job is sourcing and connecting youth with the services they need to live with their challenges. As a specialist referring youth and children back to their communities, she identifies a critical need for more support workers. Those are the contacts in the community, and more people need to be available to provide the kind of support youth and their families need to navigate the confusing and inconsistent range of services and support.

"Even finding out what's out there for a youth. That is a challenge. It can be difficult. If we don't know who's available to do what for that child having suicidal expressions – how can we help them?"

Is the problem only in rural or remote communities?

While there might be more services in major centres like Vancouver, they aren't often as accessible – and awareness about the programs and services available is very low – even among the service providers.

In fact, it can sometimes be easier to collaborate in smaller communities where they are better personal networks and relationships.

The lone part-time hospital social worker in a small community outside of Vancouver says smaller communities have informal networks that serve to look out for their neighbours. But there are acute gaps in service. For example, the local hospital is not able to admit youth who present at emergency in psychiatric crisis; the whole coastal community is served by a once

a month visit from a child psychiatrist. There is only part time coverage for mental health crisis coordination.

In this community, when a youth or child presents at emergency in crisis, there are double standards for treatment. If the issue is non-psychiatric, the patient is eligible for the patient transfer network that transports them under care to a larger hospital on the Mainland. If it's a psychiatric issue, the patient does not fall under the patient transfer network. In extreme cases, in collaboration with the on-call Mainland psychiatrist and the coastal community emergency doctor, transport may be arranged provided there is capacity at the Mainland hospital to accept the patient. If the child is not accepted, and because the community hospital is not resourced to admit youth with psychiatric needs, the youth is turned back into the community, with follow-up as possible by the social worker, who works to connect the patient with available community resources. In some rare instances, medical staff will collaborate to admit the youth, even though the resources are not there for them, but it comes down to being a judgment call about where the youth will be safest at that critical time.

In one of the province's most populous health authorities, a youth care counsellor who has worked in adolescent psychiatry for more than 20 years credits the school system for increasing its capacity for identification of children and youth exhibiting signs of mental health issues. While the result is increased awareness and recognition of signs and symptoms – and referrals for service – there just is not the capacity to address the needs.

A hospital psychologist in the Lower Mainland agrees that resources in schools just aren't able to deal with the demand. Limited funding for services including counselling and school-based psychologists often means that only the most acute situations can be addressed, and that means that less acute situations are left untreated – at a time when intervention could make a difference for a lifetime.

For example, youth with OCD may just need to a longer time period to complete an in-class essay – to accommodate for repetitive erasing and writing; students with anxiety disorders may need access to a small space to work in. But getting a diagnosis is critical in order to recognize the adjustments needed to avoid disorders that may spiral out of control. And the waiting lists for assessments can be too long.

With the majority of available resources devoted to the acutely mentally ill and/or addicted, prevention just doesn't factor in in any significant way.

Early intervention must be a priority, say health science professionals working in child and youth mental health. Mental health problems become more acute as youth enter their teens, but if the challenges can be identified, and interventions put in place before that critical time, a marked improvement in the short and long term is absolutely attainable.

The focus on early intervention is recognized as a key by so many in the community, but because the focus is on triaging and treating acute circumstances, early identification and treatment suffers.

Another critical gap is in diagnosis and treatment of concurrent disorders. In practice, there is no uniform approach to dealing with concurrent mental health and addiction disorders. There are few youth mental health workers trained and experienced in addressing concurrent disorders, although there is a high incidence of concurrent disorders in the population. In some cases, youth are not given access to detox or rehabilitation for their addiction issues if they are not receiving mental health treatment, while in other cases they can't get access for their mental health issues until their addiction issues are treated.

Communication:

The gaps in the system are not restricted to service. A critical gap is in communication.

These gaps cover the whole range of communication: from children and youth identifying their issues, to families helplessly and desperately trying to support their child through their school or community services, to identifying those services, to mental health and addictions professionals communicating with each other, and to inconsistent transfer of or sharing of information.

Many of these gaps in communication are systemic – built up over years of patchwork development of services: where hospital psychiatric units don't know what resources are available in the community; hospital in-patient and out-patient programs are separate entities that lack awareness about the other's work; a patient can be seen a dozen times in Emergency, yet the outpatient program that has been working with the patient for a long period of time is not aware of the Emergency visits; a youth receiving services through MCFD in the community can present at the hospital and receive a completely new and different diagnosis because there is no communication between the two agencies, and the list goes on.

An eye-opening example of the extremes in even the basics is described by a youth psychiatric counsellor:

For example, Health Authority staff are not allowed to text their patients – to check in, to remind them to attend a group, or to complete a task recommended in treatment. Outside of the realm of services provided by the Health Authority, if a youth has access to an MCFD mental health support worker, communicating by text is the norm.

Without the ability to go to where the youth are – and in this age it is on their phones – service providers lose the ability to stay connected and support them. And the inconsistency in service delivery serves to frustrate consumers.

Obstacles to communication are not restricted to the patient-practitioner relationship. Privacy and other policy protocols can get in the way of effective treatment and communication.

Communication challenges in mental health delivery can be improved. A siloed approach often means that work being done through in-patient service isn't communicated to programs delivering out-patient services to the same individual in the same hospital.

Electronic records systems are incompatible, and make information sharing next to impossible.

A patient who may be receiving regular treatment in an out-patient program can present at emergency at the same hospital, and treating staff there may be unaware of the diagnosis or services the patient is receiving on a regular basis. In other cases, patients may report they are receiving services in the community, but by the time the cumbersome process of requesting and receiving patient information is completed, the patient is likely to have been discharged – until the next time they present and have to start from scratch again.

Treating mental health professionals often have to count on self-reporting, and while some clients and patients can be good at knowing and communicating their diagnosis, more often than not when patients and families arrive at emergency, they are in a state of crisis, and may not be able to report accurately. And they have to tell their story over and over again.

Without a clear picture of the patient's history, circumstances, and progress – in spite of being involved with the mental health system for years – practitioners and consumers are frustrated in a repetitive cycle.

A tremendous gap in service and communication occurs when youth transition into adulthood.

At 19, access to youth services is cut off, and post-secondary-aged youth are thrown into a new system, forced to learn to navigate on their own. The lack of support for transition is identified repeatedly by child and youth mental health workers as presenting a serious setback to young people at a critical time.

As outlined in Turpel-Lafond's 2013 report, adult mental health clinicians reported that a majority – 76 per cent – are not involved in planning for incoming adult mental health patients transitioning from youth services.

Best Practices:

Youth mental health practice is inconsistent in British Columbia. Practitioners agree that best practices must be evidence-based, adaptable to communities' needs, understood by all practitioners and, most importantly, structurally supported.

What is needed is a collaborative approach to maintaining an evidence-based model for mental health care in the province, and infrastructure to ensure the best practice protocols don't drift.

The province's February 2003 Child and Youth Mental Health Plan identified training and education strategies as important elements of implementation of the plan, and cautioned that "research indicates that training and education strategies alone are not sufficient to implement or maintain changes in practice. Mental health clinicians must be supported and held accountable in their practice by appropriate clinical supervision and mentoring."

With the pressures on scarce resources, the standard of adherence to best practices has suffered.

One mental health worker recalls a push in the mid-2000s on training and education on best practices. Training was developed, hundreds of practitioners were put through the training, and evidence-based best practices were implemented. What was lacking was the follow up. "People just go back to their own routines."

As identified in the 2003 plan, "…training and education strategies alone are not sufficient to implement or maintain changes in practice. Mental health clinicians must be supported and held accountable in their practice by appropriate clinical supervision and mentoring. This requires that regions ensure the availability of supervisors with expertise in children's mental health across the province."

In a climate of scarce resources, clinical supervision is often seen as expendable: the focus is on direct patient service. In small communities, where there is no or little coordination of youth mental health services, best practices don't enter into the picture.

A lone hospital social worker, early childhood education specialist, youth counsellor, or registered psychiatric nurse with a high workload and varied range of patients, clients, and families working in a small or remote community often does not have the luxury of a collaborative multidisciplinary team working to support patients and clients. She often finds herself working independently, with little guidance, and creative approaches to challenging situations. And she has little support to keep current. But it is not only in small communities where best practices slip.

"The health care system doesn't have a way to evaluate supervisors' clinical skills in an evidence-based approach," says a hospital-based mental health worker. Very few clinicians really have training to provide the evidence based best practice."

There are solutions: education and professional development. But education and professional development is routinely denied to people who want to enhance their clinical practice. Scarce dollars are instead pooled and dedicated to global education – providing what is essentially lowest common denominator training to a wide range of practitioners. As a result, clinical skills don't advance.

In another example of the inconsistency that results from a siloed approach to mental health care, an experienced mental health worker who has worked in the acute care system as well as in the community points to the advantage for best practices in the community, where accreditation is required. He believes there is a stronger commitment to evidence-based best practices in community services as a result, and that the acute care system is far behind.

Another mental health specialist working in acute care advocates for a strong commitment to ensuring best practices are followed, hand in hand with concerted resistance to best practices drift. It would not, she said, be out of line to ensure there are consequences if the standard is not met, and incentives offered for meeting them.

Resources:

Scarce resources have been a significant factor in the challenges associated with providing effective child and youth mental health services across the province. But those working in the field believe that improved management of the system can result in more effective use of resources. As one worker describes: "The capacity is there. We just need the time, relationships and flexibility to get there."

Critical to improved management is addressing the challenges of communication, and breaking down the walls between services that should be complementary – not isolated. That starts with understanding where the overlaps across Health and MCFD and other ministries, as well as other agencies, are. It's a simple concept, but a mammoth undertaking. "We need the organizational commitment and time to do it. Effective communication takes time to develop."

A concerted effort at early intervention will also pay dividends in the longer term. "If we can connect with children, youth, and families – that can lead to earlier detection and treatment and more successful outcomes."

A centralized, accessible, and on-line resource that provides support for identifying mental health issues, offers strategies for self-care, and provides access for crisis intervention and support is a model that is meeting with success in other jurisdictions. A project is currently underway to develop such a resource to serve British Columbians, and must be properly resourced.

Strategic and creative approaches to best practices that best serve individual communities should be factored into funding models. And that includes providing outreach and support workers in communities to increase accessibility to services. As a small community mental health worker describes: “We have a lot of expertise. How we use that expertise to serve youth, rather than make youth adapt to our structures, needs to be considered. We don’t need a new hospital or a new agency. We need people doing it well to work together to coordinate the services. “

Conclusion

Mental health workers have a lot to offer the system, and they must be heard.

The issues identified in the 2003 and 2008 Youth Mental Health Plans for BC, the 2013 report by the child advocate, and by HSA members in this submission have not changed substantively. The same issues: gaps in service and communication, inadequate resources to support early intervention, and difficult navigation of a disjointed collection of services continue to define the delivery of child and youth mental health services in BC.

Renewed attention and increased general awareness about the issues presents an opportunity to make progress toward the goals set out for the past decade.

Mental health practitioners, families, and consumers continue to be the best advocates and activists for driving improvement. Local efforts to break down silos, and create collaborative working groups aimed at providing services and support that works for the community and the patients are being pursued. Initiatives to broaden and provide services to children, youth, and their families in accessible ways are being explored and supported.

A key to success at moving the system toward the goals set out for the past decade will be listening to and working with the best advocates for a successful system.

The lesson from the health care worker with a child in severe mental health and addiction crisis is that direct care providers, consumers, and family members need to be able to drive the services. “They need to feel valued and know that they have a voice.”

The same rings true for the mental health workers the system relies on. They must feel supported and heard when they speak up about the challenges they identify in the system, and solutions they can explore.

"It is important to have better communication vertically. Decision makers could benefit tremendously if they actually consulted with front line workers who have a wealth of experience and truly are clinical experts."