Mental Health Initiative for Family Court Committee— February 4, 2005

The responsibility of the Family Court Committee is to reduce and to improve the functioning and the outcome of the juvenile justice system but by the time a child or youth comes in contact with the law, many of the patterns are established. It is becoming increasingly evident that most of the youth in detention have primary mental health issues and the same is true for a large percentage of the clientele of the family court and youth justice systems.

The Family Court Committee has expressed the wish to complete the Mental Health piece of the Millennium Report. It also recognizes that prevention or early intervention is preferable to treatment after a problem comes to the attention of the youth justice system or surfaces as a major problem in the home, school, or community and is only given attention after the problem has become established and ingrained. Often conditions affecting behaviour have their origin in genetics or very early fetal development. Others are due to an adverse home or social environment, in particular faulty parenting and family breakdown. Regardless of the cause, early identification, assessment, and intervention are important in achieving the best outcomes and preventing secondary problems. The sooner the child receives treatment, the more effective the intervention and the better the eventual mental health and social functioning.

A recurring theme are complaints about the length of time and the severity of offence that must occur before a child or youth receives assessment. There are also complaints about the difficulty in obtaining coordinated services from ministries that have a responsibility for only a portion of a child/youth's treatment or educational programme. Turf, funding, jurisdictional, and communication issues all play a part in this fragmentation and poor communication and sharing. Developmental/Psychiatric medical services are frequently required but referral mechanisms, waiting lists, and the need to involve multiple specialists for children and youth may cause delays of months and occasionally years before a child or youth obtains the necessary level of expertise. Developmental difficulties such as ADHD, Autism Spectrum Disorders, Personality Disorders, or more classical mental health issues particularly depression and bipolar disorder and the full range of behavioural disorders are difficult to diagnose and require an array of resources making management difficult and complex.

There are certain periods in the life of a child and youth that are especially strategic for problem identification and effective intervention. Simplistically these can be separated into preschool, early school, and late school age groups. For children, often the largest part of their waking day is spent at school. This makes, the classroom particularly strategic in recognizing and identifying problems which often are having a severe impact on school performance. In addition, problems are recognized in the doctor's office or identified through mental health services that have educational implications. When mental health services that require medical involvement are required, the length of time for a child to be seen by the family doctor, waiting for a specialist and eventually accessing the right treatment or preventative programme is often excessive and the mental health problem may intensify and become much worse during the waiting period while school performance declines and family life and community living becomes increasingly

dysfunctional. Identification and treatment are complex and accessible resources are often insufficient and may become ineffective because of delay.

The VFCYJC is essentially an advocacy committee but one that has strong links to government at the regional and the provincial level and is likely to be listened to. The committee derives its authority not only from the municipalities and region which it represents but also from the Ministry of the Attorney General and MCFD to which it is legislatively responsible.

A significant goal for the committee is to make mental health services for youth more accessible and more relevant at the community level. Another goal is to break down accessibility and communication barriers that interfere with the timely provision of services to children and youth. The silos of service delivery need to be integrated so that the needs of the child are planned with the child as the focus with single entry seamless and coordinated service. In making services more accessible, it is not enough to simply reconfigure the model of service delivery even though that may be helpful, but the resources available and therefore the funding must be increased.

I suggest two initiatives for the FCYJ to support and oversee. These would be pilot projects which, if successful, could serve as a model for province wide service delivery.

Each pilot project would see a mental health programme established in a school or a closely situated and convenient community resource. One would be directed more to developmental issues such as Foetal Alcohol Syndrome, Autistic Spectrum Disorder, ADHD, etc. and this should be sited in an elementary school. The second, sited in a high school would have a greater emphasis on teenage adjustment issues, mood disorders such as anxiety and depression, and personality disorders. It would not primarily be targeted at substance abuse but issues surrounding drugs and alcohol as co-morbid disorders would need to be considered.

The components and characteristics of the pilot project would be as follows:

Pilot 1.

Open referral in discussion with the team. Some of the problems would be simple and could be dealt with by simple discussion and appropriate advice; others would be more complex and would need complete assessment.

The team, in addition to liaison school personnel might consist of:

1. A medical doctor knowledgeable in the area of developmental disabilities but especially ADHD and learning disorders.

2. A psychologist skilled in psycho-educational testing and diagnosis

3. A social worker.

4. A counseling psychologist skilled in behavioural management who could work on an ongoing basis with a child, the teacher, and the family and any other outside treatment resources and community resources.

5. A skilled child care worker to work intensively with identified children.

Pilot 2

This team would be somewhat similar in composition to that for Pilot 1 except that it would have a stronger treatment function and would need more counseling resources.

1. The physician preferably would be a child psychiatrist but at the least would have a good knowledge of mental health conditions.

2. There would still need to be a diagnostic psychology component but there would be a greater emphasis on counseling or clinical psychology.

3. The social work requirement would likely not be as great as for the younger age group.

4. An informal youth counselor who could have a background in psychiatric nursing, psychology, or as a child and youth worker.

5. A teacher who would act as coordinator.

The teams would work with the children and youth in conjunction with the school as required throughout the year. The various positions would likely not be full time and would be adjusted according to need.

The advantages of service provision from what currently exists is increased accessibility, fewer barriers and referral hoops to jump through before definitive therapy begins. Referrals to outside resources would be expedited when necessary but avoided where treatment needs could be handled effectively with the team.

Privacy would be respected but classroom teachers would receive feedback with regular informal and formal communications. The family doctor would receive reports for specific interventions. A student or a student's family could self refer and school personnel could refer directly without having to go through layers of bureaucracy.

The school mental health support team ought to greatly assist educators in managing conflict within the school setting and in managing acting out behaviour and in recognizing developmental and psychiatric problems.

The approach would be holistic because the teacher, community worker, and family would become involved as members of the team. A school or community setting would promote much

more interaction and would help ensure therapeutic interventions were more flexible, more interactive, and better adjusted within the subject's living environment. .

Outcome monitoring and analysis would need to be part of the programme to test for effectiveness and cost efficiency. If successful, it could be introduced as a provincial program. Modification would be necessary based on available professionals in different communities.

Process

- Formalize a FCYJ subcommittee
- Invite and meet with strategic representatives of VIHA, Youth Mental Health, Education, and Representatives from Community Mental Health in MCFD and Representatives from Community Services (Boys and Girls Club)
- Enlist support of Municipal Councils (may need a dog and pony show)
- Develop an outline to present to government—Remember this will be an advocacy exercise based on the committee's local experience of community needs.

This committee does not have the resources to create a detailed plan ready to be implemented but it could hire a health planner/programmer working with a steering group drawn from the FCYJ.

It is expected that the recommendations from the FCYJ would be passed on to the Policy and Planning Group within the Ministry of Health with a view to government support and funding.

Time lines—Meet monthly and have a proposal for presentation to government by June 2005.

Basil Boulton, MD, FRCP, Member of Family Court Committee

2019 Update to this document:

The Family Court held a multi-stakeholder meeting in 2005 at Boys & Girls Club with all key stakeholders as identified in this report. The outcome was a working group, constituted as a subcommittee of the Victoria Family Court & Youth Justice Committee, which continued to develop the proposal and brought it forward through Resolution(s) to the Association of Vancouver Island and Coastal Communities/Union of BC Municipalities where it was supported.

Meetings with Ministers and Deputy Ministers occurred with Dr. Boulton and myself (Cynthia Day) and support was significant although achieving a project was difficult due to the shared responsibilities of many ministries and no single lead other than VFCYJC. We spoke often about the silos in government and the big changes that were underway at that time in the Ministry of Children and Family Development, leaving them with little opportunity to take the lead on youth mental health until the changes were complete.

A Request for Proposals was posted, a consultant was hired, and the Pilot projects were presented to the local School Districts (61 & 62) Ministry of Advanced Education, VIHA, Ministry of Health, Ministry of Children and Family Development and the Premier's office. Supporting resolutions were also carried at the Association for School Trustees. School District 62 eventually took the lead, establishing a Youth Clinic with significant support from VIHA (Community Health Initiative) and support from the West Shore RCMP School Liaison Officer, Scott Rothermel, and the Mobile Youth Services Team, including Mia Golden. School District 63 was also very interested in a Youth Clinic, but difficulties with finding space limited their ability to initiate a similar program.

In 2017, members of the Saanich Peninsula Local Action Team (medical advocacy) identified a critical need for a Youth Clinic on the Peninsula. Many advocates came together to support this initiative including Dr. Kate Evans, who opened the clinic for youth and arranged for additional supports. The clinic was enormously successful and garnered support from a core of youth volunteers who advocated, advertised and provided on site support for students accessing the clinic. The clinic had difficulty working within the provincial fee schedule structure, to cover the overhead costs to operate long enough to make the case to the province for a different funding model. In 2018, the Victoria Family Court & Youth Justice Committee, provided additional funding (from the reserve established for youth mental health) to allow the Saanich Peninsula Youth Clinic to operate long enough to establish the statistics and make the case for additional and differently structured provincial funding. The Clinic is open, successful and being funded through provincial ministries.

More than 14 years of advocacy for youth mental health has resulted in at least three fully functioning Youth Clinics accessible to youth in the Capital Region. Two of those are in a school setting. Dr. Boulton would be pleased, but he would want more – specifically he spoke often of the importance of early intervention, at the elementary school level – where both youth and those who work with them could receive valuable support to overcome mental health challenges.

Cynthia Day, Chair Victoria Family Court & Youth Justice Committee/Youth Mental Health