Highlighting Current Needs in Addressing Youth Mental Health in British Columbia

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Abstract

In 2017, undergraduate medical students in BC decided as a collective to advocate at the provincial level on the subject of youth mental health. This paper outlines key gaps and evidence–based recommendations to improve BC's youth mental health system, including: the introduction of mental health literacy programs for primary and secondary schools as a form of primary prevention; implementing simplified data collection and information sharing to facilitate coordinated care between different service providers; initiating one–stop shop and place–based models of care for improving accessibility; and reemphasizing a need to meet the Truth and Reconciliation Committee's Calls to Action regarding Indigenous health.

Introduction

Children and youth (0-24 years old, as defined by the United Nations) are vulnerable to mental illness, particularly due to the extensive biological, personal, and social development of early life.[1] Indeed, over half of young adults reported their mental illness first appeared during childhood.[2] Therefore, investing in positive mental health early on in life represents an opportunity to develop lifelong mental wellness.[3]

In BC, the prevalence of mental illness in children and youth is estimated to be 12.6%,[4] with depression affecting as many as 3.2 million youths aged 12 to 19 in Canada.[5] Although many service providers are already taking steps in supporting youth in BC, we aim to highlight evidence–based improvements that should be made in the areas of primary prevention, service coordination, accessibility, and Indigenous health.

Primary Prevention

Longitudinal studies show that the majority of mental illnesses arise in childhood and adolescence.[6-8] Evidence also suggests that classroom–based programs can substantially improve mental health.[9] Therefore, mental health literacy programs that are implemented in schools may help to prevent initial occurrences of mental illnesses, leading to an improvement in mental health outcomes and a reduction in need for later crisis management.[4,9-12]

An example of this is FRIENDS, an evidence–based cognitive behavioural primary prevention program in BC, offered at three different time points: grades K-1, 4-5, and 6-7. This program was endorsed by the World Health Organization as an effective management program for anxiety[13,14] and taught skills such as emotional awareness, problem solving, and interpersonal communication.[15] A program evaluation of FRIENDS found significantly improved levels of anxiety and self–esteem, and a qualitative assessment found the vast majority of participants thought the program was fun (81%), would recommend it to a friend (77.4%), had learned new skills (72.8%), and had used their skills to help someone else (41.1%).[39]

In June 2018, the Ministry of Children and Family Development (MCFD) discontinued its license with the FRIENDS Program. The reason for this discontinuation is not clear, but there is now a gap in evidence–based mental health education available for grades K-7. Furthermore, in secondary schools, only North and West Vancouver have integrated mental health courses in their curriculum.[16] These shortages result in a significant need for primary prevention programming aimed and delivered to BC youth.

Coordination of Mental Health Services

There are multiple youth mental health providers across BC, spanning local health authorities, the MCFD, the Ministry of Health, private psychology clinics, school counsellors, family physicians, and community agencies. These service providers lack infrastructure to efficiently communicate and coordinate with one another, especially due to legislation that restricts the sharing of information.[17,18]

Strategies to increase the coordination of services must be collaborative between different providers. For instance, the Responsive Intersectoral Children's Health, Education, and Research Initiative and the BC Children's Hospital Emergency Department's Vulnerable Youth Working Group has developed a "Situation, History, Assessment, Recommendation, Disposition Script for Community–Emergency Department Communication."[19] This facilitates direct communication and timely sharing of critical information between front–line community agencies and BC Children's Hospital. Such initiatives could be used as a framework for efficient and timely information sharing amongst other service providers.

Coupled with an additional lack of a centralized data collection system between the various service providers—and without simplified access to and analysis of those data—a significant gap in standardizing and enabling the coordination of services will persist. Creating reliable province–wide infrastructure for mental health data collection and information sharing has the potential to enhance both the coordination and quality of youth mental health care in BC.[18]

Accessibility of Mental Heath Services

Approximately 35% of youth aged 10-19 had their first contact with BC's mental health system in an emergency department,[20, 21] indicating that youth may be waiting until a moment of crisis before receiving care. Accessing the myriad services can be difficult for youth, especially for those without the means to navigate services located outside of their community.

Evidence–based recommendations to resolve these issues include taking a "place–based" approach to services, where mental health professionals meet with youth at locations where they spend most of their time, such as schools and community centres.[22, 23] School–based mental health services have been shown to improve access to mental health and substance use services by minimizing physical, financial, and social barriers to accessing care.[24-26]

Evidence also suggests that youth prefer to access services in one location, where a place–based model can also serve as a "one–stop

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shop."[27-29] An example of this is the Foundry, a provincial initiative run by Providence Health Care, which delivers primary care, mental health, and social services in centres throughout BC.[30, 31] An early satisfaction survey of the first Foundry Centre (previously known as the Granville Youth Health Centre) found a high level of satisfaction with youth–friendliness and the benefits of integrated services. These results mirror the experiences of other "one–stop shop" integrated health centres around the world, including Headspace Centres in Australia and Headstrong Centres in Ireland.[32-33] Addressing the issue of access to youth mental health services is imperative to closing gaps in care. It is important for all youth in BC to have the care they need, when they need it. A place-based approach is a way of increasing access to mental health resources for youth in BC.

Indigenous Youth Mental Health

First Nations, Métis, and Inuit populations experience far greater health inequities than non-Indigenous Canadians.[34-37] Multiple factors contribute to this inequity, including the intergenerational effects of residential schools, familial deaths, racism, and the dismantling of culture.[34,38] Indigenous youth suffer a disproportionately high burden of mental illness: for example, the suicide rate among all Indigenous youth aged 15-24 is 5-6 times the national average, and as high as 11 times the national average amongst Inuit youth.[6]

In 2015, the Truth and Reconciliation Commission (TRC) published 94 Calls to Action[38] to address the legacy of residential schools and strive towards reconciliation. Three of the Calls to Action (#22, 23, 24) can be specifically achieved within the medical community through collective and individual action across workplaces, hospitals, medical schools, clinics, and health authorities. The Calls to Action include concrete steps that can be taken, such as recognizing the value of Indigenous healing and integrating practices collaboratively with traditional healers and Elders; increasing the recruitment and retention of Indigenous healthcare providers; developing continuing medical education courses in Indigenous health; and providing mandatory education and training for current physicians and medical students on the colonial history of Canada, Indigenous rights, anti-racism, and applied cultural safety. By addressing the TRC's Calls to Action, healthcare professionals can collectively work towards reconciliation and support the mental health and wellbeing of Indigenous youth in BC.

Conclusion

The youth mental health services spectrum in BC is complex and multifactorial. It requires systemic change and a holistic implementation of primary prevention, improved coordination and accessibility of services, comprehensive substance use and addiction services, and a collective effort to meet the needs of Indigenous youth. Specifically, there is a great need to expand primary prevention programs by implementing appropriate mental health education into the school curriculum for students of all ages. In conjunction, prioritizing the establishment and dissemination of infrastructure for data collection and information sharing can ensure coordination and communication between disparate mental health services. This concept can be further expedited by place–based approaches to youth mental health services that emphasize schools and community centres as early access points. Services should also be expanded to support a full spectrum of substance use and supportive recovery services for youth who are living with concurrent and complex mental health disorders. New models of clinical management can focus on building therapeutic relationships through youth–centred, trauma–informed practices. In particular, collaborations with Indigenous communities to address and respond to the TRC's Calls to Action #22, 23, and 24 will contribute to the ability to provide youth mental health services in culturally responsive ways.

Limitations

The intent of this piece is to highlight some of the gaps in services from prevention to treatment of youth mental health. As this is not an exhaustive list, there are many issues and policies that were not discussed that could be the focus of future policy development and research. Of particular note are the issues of adverse childhood events, role of the family in youth health, mental health and addiction amongst youth both within and aging out of government care, as well as issues of secure care, which should be further reviewed.

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