FINAL RESEARCH REPORT:

A CHILD AND YOUTH MENTAL HEALTH AND ADDICTIONS FRAMEWORK FOR THE YUKON

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Note to Reader

This report presents the findings of a research study that served as the basis for developing a child and youth mental health and addictions framework for Yukon. The framework is presented in an accompanying document entitled "A Child and Youth Mental Health and Addictions Framework for the Yukon" that is available from the Yukon Government Health and Social Services website at http://www.hss.gov.yk.ca/mental_health.php or by request from the Corresponding Author (Dr. Gillian Mulvale) at mulvale@mcmaster.ca. Highlights of the framework are presented in Section 5.1 of this document.

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*Appendices are available upon request from the corresponding author (Dr. Gillian Mulvale) at mulvale@mcmaster.ca.

List of Abbreviations

General
ASD: Asperger's Spectrum Disorder
EPI: Early Psychosis Intervention
FASD: Fetal Alcohol Spectrum Disorder
FN: First Nation
MH: Mental Health
NGO: Non-Government Organization
SA: Substance Abuse

Yukon
ADS: Alcohol and Drug Services
CAFN: Champagne Aishihik First Nation
CATS: Child Assessment and Treatment Services
CDC: Child Development Centre
FSCD: Family Supports for Children with Disabilities
HSS: Health and Social Services
ILC: Independent Learning Centre
KDFN: Kwanlin Dun First Nation;
MHS: Mental Health Services
RYTS: Residential Youth Treatment Services
TKFN: Ta'an Kwäch'än

Alaska
BTKH: Bring the Kids Home
FWWI: Family Wellness Warriors Initiative
SCF: Southcentral Foundation

Hawaii
CAMHD: Child and Adolescent Mental Health Division
HFAA: Hawaii Families as Allies"

Manitoba
HCCC: The Healthy Child Committee of Cabinet
HCM: Healthy Child Manitoba

Ontario
EDU: Ministry of Education
MAG: Ministry of Attorney General
MCSCS: Ministry of Community Safety and Correctional Services
MCSS: Ministry of Community and Social Services
MCYS: Ministry of Children and Youth Services
MOHLTC: Ministry of Health and Long-Term Care

Key Messages

This research report describes and synthesizes input from Yukon stakeholders (youth and family members, service providers and policy advisors) gathered through interviews, focus groups, a clinician workshop and a policy dialogue. It also includes findings from literature review and interviews with key informants from other jurisdictions. Together this data was used to develop a Child and Youth Mental Health and Addictions Framework for Yukon.

Yukon's population of approximately 38,000 people is concentrated in Whitehorse. Geographic distance and inclement weather challenge service delivery by visiting counsellors to the many rural communities of several hundred people. Yukon study participants described a marked disparity in terms of access to mental health care between children and youth in Whitehorse compared to many rural communities. Addressing this disparity was a priority for Yukon Working Group members. Service gaps also exist for youth with moderate mental illness or mental health problems that do not meet the diagnostic criteria to be classified as a mental disorder. Many of these youth could benefit from preventive mental health care such as supportive counselling and learning coping skills.

Historical factors have led to complex governance structures and imbalances in resource allocation across programs and agencies. Operational silos and funding patterns challenge comprehensive and coordinated approaches to service delivery. A coordinated continuum of services that span promotion, prevention, intervention and ongoing care is needed.

Families and youth participants want more information about how to access services and made suggestions to improve system navigation, coordination and information sharing. Families described substantial out-of-pocket costs for travel to services and identified the need for improved parenting skills and support. **Yukon service providers, clinicians and policy advisors called for expansion of efforts to move 'upstream' to focus on promotion and prevention** such as socio-emotional learning programs in schools, programs targeted to at-risk parents and culturally sensitive programs.

Participants from other jurisdictions had several recommendations:

- **Locate services within or close to communities** to avoid cost and difficulties associated with travel to services. This can facilitate development of culturally appropriate mental health care in rural communities, supported through telemental health.
- **Implement coordinated approaches to care delivery**. These include, collaborative interdisciplinary delivery, wrap-around and case management approaches, and the integration of mental health and addiction services. School-based mental health literacy, promotion, prevention, socio-emotional learning and school-based counselling were recommended.
- **Dedicate funding to ensure providers are knowledgeable in evidence-based clinical interventions and to enhance mental health literacy and care competencies of human service workers and volunteers.** Establish service delivery and outcome expectations but allow diversity in delivery approaches. Require that programs be evidence-based and include ongoing accountability and evaluation mechanisms.

Working Group members recommended inclusion of statements of core values, common language, and clinical guidance with a focus on the needs of youth and families, in order to overcome silos in delivery.

A comprehensive approach that places greater emphasis on promotion and prevention along with best evidence based care, child and youth mental health competency development, and a cascading model of service delivery is proposed. This approach can leverage existing human resources and telehealth capacity to offer community-based care. Implementation will require top-level political leadership, a staged approach, and transitional funds until savings are realized.

Executive Summary

This report presents the findings of a policy research study that produced a comprehensive child and youth mental health and addictions framework for the Yukon (hereafter referred to as 'the Framework'. A Yukon Working Group (Yukon Health and Social Services & Education, Kwanlin Dun and the Yukon Council of First Nations), and researchers from McMaster and Dalhousie Universities conducted the research. The study was funded through a Canadian Institutes for Health Research (CIHR) Evidence-Informed Policy Renewal Grant.

The research reported here builds on the findings of the Yukon HSS Child/Youth Mental Health Study group and the knowledge of child/youth mental health strategies and stakeholders engagement strategy used in developing *Evergreen,* Canada's national child and youth mental health policy framework. The goal of the Evergreen project was to create a national framework to serve as a guide for development of child and youth mental health frameworks at the local level. The Evergreen framework contains core values and strategic directions across the continuum of Promotion, Prevention, Intervention and Ongoing Care; and Research and Evaluation.

The objectives of the current research were two-fold:

1. to develop a revised child and youth mental health framework that is tailored to the Yukon context, and in so doing,
2. to assess whether and if so how**,** a national health policy framework like Evergreen could be helpful in provincial/territorial health policy making.

A mixed methods case study design was used along with a community-based participatory policy research approach. Data on the Yukon context was collected from multiple sources, including document content analysis and key informant and focus group interviews. Participants included youth mental health consumers, family members, service providers, policy advisors and representatives of three First Nations communities. Data from comparator jurisdictions were drawn from documents and key informant interviews.

The findings suggest that the small population in Yukon clusters along two polarities with respect to income, geography, culture and mental health and addictions services available. Participants described a high median income that is mostly enjoyed by a more advantaged, non-native population located in Whitehorse, and a less-advantaged population in the outside communities. Many participants noted that the mental health needs of the two populations are not being met equally. Comprehensive approaches are required to address these disparities in order to improve the mental health and well-being of Yukon children and youth.

Yukon culture emphasizes physical health, and many cultural and other opportunities exist for children and youth living in Whitehorse that are very positive for child and youth mental health. However, a 'frontier mentality' also emphasizes mental 'toughness' and a 'work-hard, play hard' approach that can inhibit help seeking, contribute to stigma, and to high rates of alcohol and substance use. This results in significant health impacts and costs to the health and social services system.

Yukon's small population means that citizens have easy access to political and policy leaders. This can lead to a culture of risk aversion in government and some families are able to effectively lobby for faster access to services.

Historically, child and youth mental health services have been a low priority for government, in part due to historical governance

arrangements where mental health service delivery to the Territory was a federal responsibility. According to participants, mental health is now receiving more attention at the political level, with a focus on how to better utilize existing resources through collaboration and improved efficiencies throughout the system.

Improving access to services in rural communities is a high priority. Service delivery is challenged by the small size of communities in rural Yukon, geographic distances, and weather conditions that can often interrupt travel by counsellors who visit communities. Many participants felt that additional resources should be located within or close to communities to avoid cost and travel difficulties for those who require treatment. These resources could also offer mental health promotion and prevention, more immediate access in crisis situations and reduce costs associated with treatment delays.

Service gaps exist for youth with moderate mental illness. Some policy advisors felt that the requirement for a clinical diagnosis to receive mental health services can restrict access to mental health care for many youth who might benefit from information, support, counselling and learning coping skills.

Families and youth participants identified significant information needs and made numerous suggestions to improve system navigation. Poor communication and coordination across departments, agencies, schools, doctors and others caring for youth with mental disorders and addictions was a common concern of families, service providers and policy advisors. This can result in children and youth falling through the cracks between services, inefficiencies associated with multiple program intakes, and worsening mental health conditions and higher costs due to treatment delays. Policy advisor participants suggested that strong leadership is required to promote an atmosphere of information sharing across government programs and with other agencies. Moving forward, the focus should be on removing administrative barriers to collaboration in order to benefit youth and families and to free up system resources.

Policy advisor and service provider participants were very positive about existing efforts to focus on mental health promotion and prevention and would like to see these be expanded. These include identification of 'at-risk' families during the pre and post-natal periods, school-based approaches and parenting skills programs such as 'Healthy Families'. Placing more attention on improving parenting skills in First Nations communities was a common theme among family member and service provider participants. School-based counselling and socio-emotional learning programs were seen to be successful approaches that should be expanded.

Youth and family members would like providers to take a more holistic approach that includes attention to a broader range of mental health care needs, such as supportive counseling and developing coping skills, in addition to medical treatments for mental disorders. Some First Nations service providers believe that abstinence approaches within Alcohol and Drug services can hamper help seeking by First Nations youth who may benefit from information and support as they develop treatment readiness. Service delivery must also be sensitive to pervasive stigma and be culturally appropriate. Efforts to incorporate cultural approaches in service delivery to date are appreciated by participants who called for expansion of these efforts.

Many participants pointed to insufficient resources being devoted to supporting the mental health and addictions needs of children and youth in Yukon. At the same time, some participants commented that a lot of resources are available but they are fragmented and not being used in a coordinated way. Participants felt that training to improve provider competencies in child and youth mental health and addictions is needed in many areas to optimize use of existing human resources, remove duplication and

improve collaboration in planning and service delivery. A more integrated approach to mental health and addictions was called for, as well as improved collaboration between school, justice and mental health services. Lack of affordable and supportive housing options was also frequently mentioned as a concern. Policy advisor participants felt that failure to provide an environment to promote recovery places youth at risk of unhealthy behaviours.

Key informants from other jurisdictions suggest that high-level political leadership is a key requirement for successful implementation of any framework. They also stressed that fundamental transformation takes time, and that considerable time must be built into planning to negotiate support across multiple government departments and agencies. The use of telehealth and other technologies, and a hub and spoke model was recommended to deliver services to rural communities. In New Zealand, legislation that requires cultural sensitivity in all service delivery is extremely helpful in developing the political will to support culturally sensitive capacity development within rural communities.

Informants from other jurisdictions also strongly support coordinated responses to mental health and addictions needs and recommend the adoption of wrap-around and case management approaches that place the focus on youth and families to help overcome administrative and delivery silos. Participants also strongly recommended school-based approaches including socio-emotional learning, mental health promotion, prevention and literacy and school-based counselling as well as support for a coordinated service delivery model. There was strong support for interprofessional approaches to service delivery using virtual teams to provide programming across the continuum of promotion, prevention, early intervention and treatment.

Informants also suggest that system leaders keep the focus on expected outcomes through ongoing evaluation and accountability and be tolerant of diversity in approaches, as long as they were evidence-based and consistent with professional standards of practice. Dedicated funding was recommended to ensure that providers are knowledgeable in evidence-based clinical interventions and to enhance mental health literacy and care competencies of human service workers and volunteers working with children and youth.

Working Group members identified a number of objectives for the framework through a modified Delphi consensus-building process. These were: to include a statement of common values; offer clinical guidance; create a common language; and address gaps in service delivery between Whitehorse and rural communities. Clinical workshop participants emphasized the need to offer a full continuum of services, culturally–grounded interventions, improve communication across services and agencies, and provide better information on how to access services. Clinician participants also expressed their own needs for continuing professional education to better deal with the often-complex needs of the children and youth they work with.

The Framework proposes a cascading model of service delivery that can leverage existing telehealth capacity in Yukon, and aligns with a regional hub structure within Yukon's Clinical Services Plan. The model would train resident health and human service workers in each community in *basic* child and youth mental health competencies. Primary care workers would receive *advanced* competency training, and specialist psychiatrists, pediatricians and psychologists would receive enhanced mental health competency training. The cascading model has the potential for efficiency gains through reduced travel by providers to communities, improved referrals, reduced duplication, better coordination, and more immediate access to care. Transitional funding for competency development and other implementation costs may be required until these efficiencies are realized.

1.0 Background

The Yukon Department of Health and Social Services (HSS) identified the need to examine the current continuum of mental health services for children and youth, from promotion and prevention to intervention and ongoing care. The goal was to identify and capitalize on current strengths and examine resource use to determine if existing resources can be reallocated to improve outcomes for children and youth (Yukon Government, 2010, 2011).

Current Mental Health Service Delivery

A number of different areas of the Yukon government and outside organizations are involved in delivering services to improve the mental health and well-being of youth in the Yukon. Within the Yukon Department of Health and Social Services, these groups include:

Mental Health Services: provides assessment and treatment for youth with diagnosable mental disorders including a dedicated Early Psychosis Intervention Program, and co-ordinates the quarterly psychiatry clinics with the itinerant psychiatrist. The child psychiatry clinic is available to children and youth in the Yukon, and is not limited to those receiving services through Mental Health Services.

Child Assessment and Treatment Services: offers individual, family and group counselling. Counselling is focused on mental health needs arising from abuse, trauma, neglect and exposure to domestic violence and substance abuse.

Residential Youth Treatment Services manages and staffs group homes for children and youth "in the care of the Director".

Regional Services: Regional social workers are resident in small communities throughout rural Yukon. Social worker services are provided in those communities specific to the following mandates: child welfare, social assistance, youth justice, adult services. In addition, these social work professionals promote community development through their generalist approach to social work practice as well as provide referrals and linkages to specialized services available in Whitehorse.

Youth Justice: provides day treatment and prevention/early intervention programming for at-risk children and youth plus specialized forensic psychological services through contracts with itinerant psychologists.

Alcohol and Drug Services: is located within "adult services" but has a youth program that includes outpatient treatment. There are also youth workers who go into schools to provide general mental health services that are not specific to addictions.

Other counseling services offered by the Yukon government include school-based counseling services led by the Department of Education. Alternative Schools also exist that are beneficial to some youth with mental health problems and disorders (e.g. Independent Learning Centre).

There are also a number of non-profit organizations funded by government to deliver services in rural communities (e.g. Many Rivers) or to promote the well-being of youth in the Territory (e.g. the Child Development Centre).

The majority of mental health service delivery occurs within Whitehorse, or by providers who reside in Whitehorse and travel periodically to outside communities to deliver services. Each First Nation Community has a Health and Social Director, but most do not offer mental health programming. Kwanlin Dun First Nation, is unique in that it has received special funding from the Territorial Government through which it operates its own Health Centre.

Services offered include mental health counseling to youth and families as well as 'On the Land Programs' for alcohol and substance abuse treatment.

Research Study

In July 2012, Yukon Department of Health and Social Services (HSS) partnered with a team of researchers from McMaster University and Dalhousie University to propose a research study to the Canadian Institutes for Health Research (CIHR) Evidence-Informed Policy Renewal Grant Competition. The objective was to use best evidence to develop a Child and Youth Mental Health and Addictions Framework for Yukon. In March 2013, the grant was awarded to the team, with Dr. Gillian Mulvale, Assistant Professor, Health Policy and Management, McMaster University and Dr. Stanley Kutcher, MD, FRCPC, Sun Life Financial Chair in Adolescent Mental Health, IWK Research Centre and Professor Medicine, Dalhousie University as co-Principle Investigators. Paddy Meade, Deputy Minister HSS was the Principal Knowledge User on the CIHR grant and co-signatory to the Project Charter. The team worked closely with a Working Group comprised of 13 members of Yukon HSS, Education, the Yukon Council of First Nations, and Kwanlin Dun First Nation. Table 1.0 lists the full membership of the research team and Working Group.

The research builds upon the findings of the Yukon HSS Child/Youth Mental Health Study group (Yukon Government, 2010, 2011) and the knowledge of child/youth mental health strategies and experience in engaging stakeholders gained while creating *Evergreen,* Canada's national child and youth mental health policy framework, developed by Dr. Stanley Kutcher on behalf of the Child and Youth Advisory Committee of the Mental Health Commission of Canada. The goal of the Evergreen project was to create a national framework to serve as a guide for development of mental health child and youth frameworks at the local level (Mental Health Commission of Canada, 2010). It contains key principles and strategic directions across the continuum: Promotion, Prevention, Treatment and Aftercare; and Research and Evaluation.

Purpose and Research Questions

The objectives of the research were two-fold:

- to develop a revised child and youth mental health framework that is tailored to the Yukon context, and in so doing,
- to assess whether and if so how**,** a national health policy framework could be helpful in provincial/territorial health policy making, using the child/youth mental health program in the Yukon as a case study.

We set out to answer the following research questions:

- What are the unique features and special needs for a comprehensive child and youth mental health and addictions framework in the Yukon?
- How can experiences of other jurisdictions inform the framework?
- To what extent did the content of *Evergreen*, such as its values and strategic directions, aid (or not) in shaping the content of the new Yukon framework?
- What can be learned from this case about the usefulness of national frameworks for provincial/territorial health policy development?

The study received ethics approval from the McMaster Research Ethics Board, the IWK Health Centre Research Ethics Board, and was granted a Yukon Research License.

2.0 Methods

A mixed methods case study design (Yin, 2003) was used to investigate the helpfulness of national health policy frameworks to provincial/territorial policy development and to inform the development of a Yukon Child and Youth Mental Health and

Addictions Framework. Data were collected from multiple sources (document content analysis, focus groups, key informant interviews) to search for the convergence of themes and to promote internal consistency through triangulation (Trochim, 2001). Input was gathered from a range of stakeholders as listed below in 3.0. Recommendations for the framework are rooted in best evidence that reflect the goals and objectives of Yukon stakeholders, and lessons learned from experiences of other jurisdictions that face similar challenges to the Yukon.

Table 1.0
Research Team and Working Group Membership

Research Team	Yukon Working Group
• **Gillian Mulvale**, Assistant Professor, Health Policy and Management, McMaster University • **Stan Kutcher**, MD FRCPC, Sun Life Chair in Adolescent Mental Health, Dalhousie University • **Glen Randall**, Associate Professor, Chair, Health Policy and Management, McMaster University • **Pat Wakefield**, Associate Professor, Health Policy and Management, McMaster University • **Chris Longo**, Associate Professor, Health Policy and Management, McMaster University • **Julia Abelson**, Professor, Clinical Epidemiology & Biostatistics, McMaster University • **Judi Winkup**, Research Coordinator, McMaster University • **Jess Wishart**, Research Coordinator, Dalhousie University	• **Marie Fast**, Clinical Manager of Yukon Mental Health Services, Yukon HSS • **Brad Bell**, Director, Family & Children's Services Branch, Yukon HSS • **Lori Duncan**, Director of Health and Social, Council of Yukon First Nations • **Simone Fournel**, Manager, Children's Assessment and Treatment Services, Yukon HSS • **Carmen Gibbons**, Director, Health & Social, Kwanlin Dün First Nation • **Michael Hanson**, Manager, Alcohol & Drug Services, Yukon HSS • **Sabrina Kinsella**, Health Research Analyst, Yukon HSS • **Jan Langford**, Wellness Policy Advisor, Wellness Strategy Initiative, Yukon HSS • **Irene Lubbers**, Manager, Youth Justice, Yukon HSS • **Beryl Mason**, Manager, Regional Services, Yukon HSS • **Trish Smillie**, Director, Student Support Services, Yukon Education • **Cheryl VanBlaricom**, Acting Director, Policy, Practice & Program Development, Yukon HSS

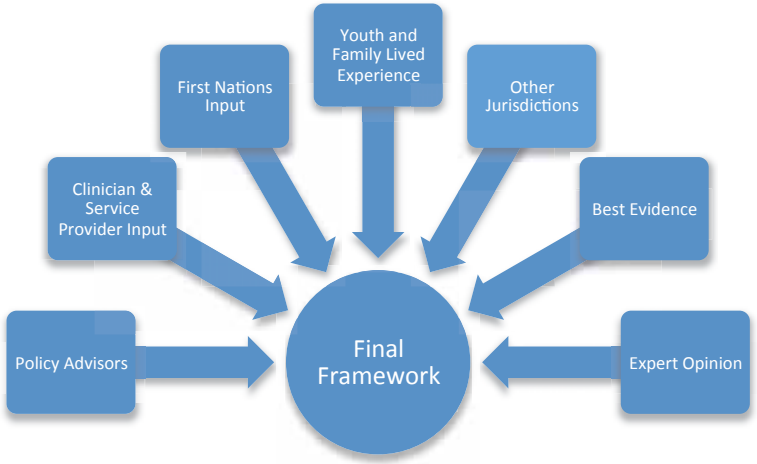
Two conceptual frameworks were used to guide the analysis and promote analytic rigour (Harrison, 2001). The first conceptual framework was the 3-I Policy analytic framework of *Interests, Institutions and Ideas,* (Howlett, 2009) which captured a range of factors that influence local policy development. Interests include considerations of different stakeholder perspectives (e.g. children, youth, family members, service providers, clinicians, managers, policy advisors, politicians) and their various roles in policy making and mental health services. Institutions include the historical, geographic, economic, social, cultural and geographic influences that have shaped services to date and the structures and laws that shape what can be done. Ideas include research evidence and deeply held values of stakeholders that must be considered in developing the framework.

The second framework was the national Evergreen Child and Youth Mental Health Framework(Kutcher & McLuckie, 2013; Kutcher & McLuckie A. , 2010; Kutcher, 2009), which was developed by the Child and Youth Advisory Committee of the Mental Health Commission of Canada to serve as a guide for development of mental health child and youth frameworks at the provincial/territorial level. Evergreen was used to guide the development of the core elements and enhanced options for the child and youth framework for Yukon. The components of the Yukon framework include common language, underlying values, mental health needs, comprehensive programming and a service delivery model that spans mental health promotion, prevention, treatment and ongoing care, research and evaluation, which are consistent with the Evergreen framework.

Community-based Participatory Policy Research

A community-based participatory policy research approach was adopted. This approach is particularly suited to the analysis of issues that are deeply rooted in the local context. In this approach, the broader historical, social, cultural and political dimensions of the issue and setting are analyzed by actively seeking the involvement of all relevant stakeholders, especially those traditionally excluded from the policy process (Freudenberg, 2005). Input was gathered from a range of stakeholders as shown in Figure 2.1, including young people family members, policy advisors, service providers and agencies and representatives of three First Nations communities. Most of these data were gathered through individual interviews. In addition, three focus groups were held with: (1) service providers in Whitehorse; (2) an interagency group in Champagne-Ashishik First Nation in Haines Junction; and (3) with First Nations Health and Social Directors by videoconference.

Figure 2.1
Participatory Policy Research



Working in Partnership

The research team worked closely with the Working Group members, who initially oriented the team to relevant background material and including government reports. Three face-to-face meetings between the Working Group and the Research Team were held in Whitehorse. The first meeting was a project kick-off meeting in May 2013 to inform research design, sampling and recruitment in the Yukon. The second

meeting provided preliminary feedback on the data gathered in the Yukon in October 2013. The third was held in April 2014 to provide feedback on data gathered from other jurisdictions and prepare for the policy dialogue. During the same visit to Whitehorse, a workshop was held with clinicians to gather their suggestions for the framework. The final face-to-face meeting was the policy dialogue held on May 26th, 2014, which is discussed in Section 4. Over the course of the study, the Research Team and Working Group also met frequently by teleconference to discuss emerging findings and come to agreement about next steps and emerging issues. Additional calls were held with Marie Fast, Clinical Manager Mental Health Services and Paddy Meade, Deputy Minister HSS as required.

Phases of Research

Figure 2.2 illustrates the three phases of research to support the development of the Framework. The understanding gained of the Yukon context in phase 1 informed the selection of comparator jurisdictions from which we were able to draw insights for the Yukon context in phase 2. Phase 1 and 2 findings, along with Yukon objectives and a clinicians' workshop about the proposed clinical framework elements were used in Phase 3 to develop the draft Framework. Note that the policy dialogue held on May 26th, 2014 in Whitehorse was a key project milestone within Phase 3. Data gathered from the dialogue participants were incorporated into the final framework.

Phase 1: Analysis of Yukon Context

The vast majority of interviews and focus groups with Yukon stakeholders were carried out face-to-face, during a week of data-gathering by six members of the research team in late October, 2013. Where face-to-face interviews and focus groups were not possible, follow up interviews were carried out by telephone and/or video-conference. Semi-structured interview and focus group guides were developed for each stakeholder group within the Yukon and pre-tested in conjunction with the kick-off meeting in May 2013. The interviews and focus group questions where guided by the two conceptual frameworks. Questions were asked about:

1. Contextual factors in the Yukon, such as the role of historical, geographic, economic, social, cultural and political factors; and
2. What works; What doesn't work?; How can services be improved?; and
3. How did we get to where we are now?; and What is feasible to change and why?

Interviews and focus groups were audio-recorded subject to permission from the participant, and the interviewers took additional hand-written notes. Professional transcribers transcribed all interviews. The interviews lasted between 45 minutes and an hour and a half.

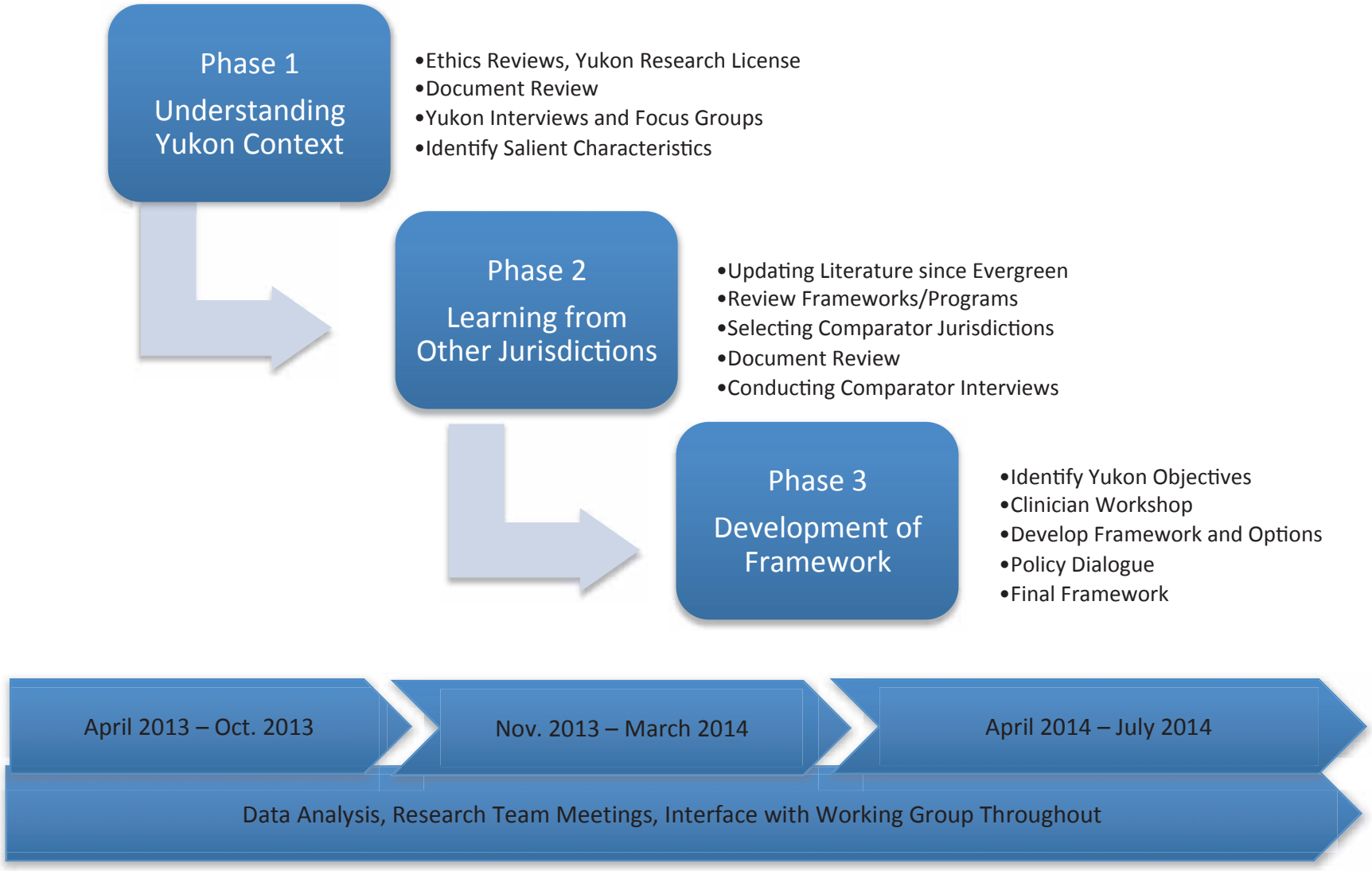
Managers and supervisors from within HSS and staff from First Nations agencies worked with the research coordinator to distribute information to youth and families who were receiving services. During recruitment, the voluntary nature of participation in the study was stressed to ensure that clients did not feel pressured to participate. The research coordinator monitored recruitment of participants.

Research team members coded the Yukon interviews and focus groups, using NVivo qualitative software. An inter-rater reliability coding exercise was undertaken in order to ensure a consistent application of the framework by members of the research team. Refinements were then made to the coding categories. Key domains within the coding framework were participants' perspectives on the salient characteristics, what is working well, what is not working well and their suggestions for improvement when it comes to child and youth mental health and addiction services in the Yukon, out of pocket costs for family members associated with caring for a child or youth

with mental illness, and the helpfulness of Evergreen in developing the Yukon framework.

Each coder undertook the coding of a different participant group in order to further ensure consistency in coding. Coding queries were used to summarize key themes for each of the participant groups.

Figure 2.2 Phases of Research Project and Framework Development



The research team met to debrief following data collection and together agreed upon six characteristics of the Yukon context which were considered critical to consider in the development of child and youth mental health services in the Yukon, hereafter referred to as 'salient characteristics.' These were discussed and refined based on a teleconference with the Working Group.

A summary of the findings for children, youth and families was sent to all youth and family participants for review and comments, and their feedback was incorporated.

Phase 2: Comparator Jurisdictions

Document review and key informant interviews were carried out in several comparator jurisdictions that were purposively sampled to inform the Yukon context.

The objective was to select a parsimonious number of jurisdictions that: (i) provide insight to the salient Yukon characteristics that were identified; (ii) had a child and youth mental health framework or relevant evidence-based programming; and/or, (iii) had governance structures that may be helpful in the Yukon context. Other guiding principles were that only evidence-based programming would be considered, and that expert opinion[1] would be used to assess frameworks and programming that are most relevant to the Yukon context. In addition, the selected jurisdictions together offered relevant programming for child and youth services across the continuum of mental health promotion, prevention, treatment and ongoing care, research and evaluation.

The existing libraries of child/youth mental health policy documents, frameworks and research associated with the development of *Evergreen* were updated to capture literature over the period 2009 to 2013. Two members of the research team searched official websites, electronic databases (e.g., PubMed etc.), checked references from selected documents, and used generic Internet search engines (Google and Google Scholar) using search terms including but not limited to 'Child/Youth Mental Health Policy' and 'Mental Health Frameworks.

Based on the salient characteristics identified in step 1, the research team and Working Group members held a teleconference to discuss together potential comparator jurisdictions with similar characteristics. This resulted in an initial list of 22 potential comparator jurisdictions. Four members of the research team together reviewed the child/youth mental health programming in each of the 22 jurisdictions to assess their relevance for the Yukon. The review suggested that seven jurisdictions had child and youth mental health frameworks: Manitoba, Alberta, British Columbia, Saskatchewan and Ontario within Canada, and New Zealand and Western Australia outside Canada. Of these, Manitoba, Alberta, and Ontario were selected within Canada and New Zealand was selected outside of Canada for inclusion as jurisdictions with relevant frameworks. In addition, British Columbia, Hawaii, and Norway were selected because of innovative programming, and Alaska was selected because of informative governance structures. 03.7 lists the selected jurisdictions, their salient characteristics and relevant mental health frameworks or innovative programming.

In jurisdictions with a child and youth mental health framework, we invited the Deputy Minister of the Department most closely aligned with Child and Youth Mental Health Policy or their delegate to participate in a key informant interview. In jurisdictions with relevant programming, we invited the lead person for the programming identified through website searches.

A semi-structured interview guide was used to conduct the interviews with key informants from comparator jurisdictions. Questions pertained to existing child/youth mental health frameworks or

[1] Note that Dr. Stan Kutcher has extensive experience developing child and youth mental health frameworks and services in countries around the world in his capacity as the Director of the World Health Organization (WHO)

programs, the process of their development, implementation considerations and how they addressed the salient characteristics of the Yukon context. Interviews were conducted by phone and lasted between 45 minutes and an hour and a half. Interviews were audio recorded and transcribed. For each jurisdiction, information was summarized pertaining to content of the framework or programming; the salient characteristics and how they were addressed; and implementation considerations in terms of barriers and facilitators. We then conducted a comparative analysis of the jurisdictions to identify common themes to inform the child and youth mental health framework in the Yukon context.

Phase 3: Develop Framework for the Yukon

In the third phase, the Research Team and Working Group jointly developed a set of objectives to guide framework development using a modified Delphi process. Input was sought from Working Group members and Senior Management from Yukon Government departments of Health and Social Services, Education and Justice via email and an online questionnaire about objectives for framework *content* and *uses,* and about *potential implementation considerations* – both facilitators and constraints.

Three rounds of Delphi questions were completed to gather and refine feedback and assess priorities. Participants were also given the opportunity to provide comments and additional input during each round of the exercise. Response rates for the three rounds were 78%, 76% and 70% respectively. The results were then presented and discussed with Working Group members at a meeting in Whitehorse on April 14th, 2014. The same evening, a workshop led by Dr. Stan Kutcher was held with clinicians who work with children and youth in the Yukon. Input was gathered on what clinicians thought would support them in achieving transformation of the child and youth mental health system in the Yukon. Participants included clinicians and managers from government departments, representatives from NGO agencies and private psychologists.

The research team drew upon the lessons learned from the Yukon and comparator interviews and focus groups, the Delphi process, clinician input and suggested Evergreen approaches to develop a draft comprehensive framework that spanned the spectrum of mental health promotion, prevention, treatment and ongoing care, and research and evaluation.

Feedback on the proposed framework was gathered from representatives of the stakeholder groups that participated in Steps 1 and 2 and policy makers in departments related to child/youth mental health in the Yukon at a policy dialogue held on May 26th, 2014. Two members of the research team, the dialogue facilitator and Yukon government representatives worked together to identify participants to ensure appropriate representation of the various stakeholder groups (policy advisors, service providers, First Nations community representatives, youth and family members). Appendix D provides the policy dialogue agenda and an anonymized participant list. The feedback from the policy dialogue was incorporated in the final version of Child/Youth Mental Health and Addictions Framework for the Yukon. Highlights of the framework are presented in section 5.1. The framework is available from the Yukon Government website at http://www.hss.gov.yk.ca/mental_health.php or from the corresponding author (Dr. Gillian Mulvale) at mulvale@mcmaster.ca.

3.0 Findings

Table 3.0 summarizes the total number of interview and focus group participants from Yukon by community and type of participant during the phase 1 interviews. The majority of interviews and focus groups were conducted in person in Yukon; most were conducted in Whitehorse and some were conducted in Haines Junction and included participants from three First Nations communities, Kwanlin Dun First Nation, Ta'an Kwäch'än First Nation and Champagne Aishihik First Nation. One focus group with service providers was conducted in Whitehorse, and another focus group was held with representatives of the various agencies that work with youth in Haines Junction. To gather the perspectives of rural communities, a focus group videoconference was held with First Nations Health and Social Directors from communities throughout Yukon.

Table 3.0
Yukon Interview and Focus Group Participants

Participant Type	Whitehorse	CAFN/Haines Junction	KDFN	TKFN	Total
Policy Advisors	15	0	0	0	15
Service Provider	24	6	2	2	34
Politician	1	0	0	0	1
First Nations Leaders[1.]	1	1	2	0	4+10[1.]
Family	7	3	3	0	13
Youth	10	3	2	0	15
Other Agencies	1	5	0	0	6
Total	**59**	**18**	**9**	**2**	**98**

[1.] One focus group with 10 First Nations Health and Social Directors from across locations in the Yukon.
Abbreviations: CAFN: Champagne Aishihik First Nation; KDFN: Kwanlin Dun First Nation; TKFN: Ta'an Kwäch'än

3.1 Phase 1: Understanding the Yukon Context

The interviews and focus groups provided insight into salient characteristics to be considered in the Yukon context. Participants discussed a complex interplay of political, governance, economic, cultural and geographic factors that are important in developing the Framework. We discuss these characteristics and their suggested influence below. Further details are available in Appendix A.[2] In section 3.2, we discuss participants' perspectives on 'What is Working Well', 'Problems and Challenges' and 'Suggestions for Improvement.'

Geographic Characteristics

Yukon has a population of approximately 38,000 residents. Relative to its population size, Yukon has a vast geographic area that presents particular challenges in service delivery. Approximately 26,000 residents live in Whitehorse and the remaining population lives in 14 small, mostly rural communities, many of which are a mix of First Nation and non-First Nation residents. Dawson City is the largest of these communities with a population of approximately 1300 people. Most other communities have only a few hundred residents. Some communities are in remote areas with limited access by road. One is a fly-in only community. This challenging geography makes it difficult to provide consistent, timely mental health services to families and youth needing assistance.

Current service provision to communities outside of Whitehorse is often by itinerant workers whose schedules permit visiting a given community about once a month. Travel restrictions due to road closures and extreme cold temperatures are not unusual during the winter months. This can results in a lack of continuity in the delivery of services to youth and families. In some communities there are social work offices that focus on community development and may offer

[2] Appendices are available from the corresponding author (Dr. Gillian Mulvale) upon request. Contact mulvale@mcmaster.ca.

general counseling services, but there is limited provision of child and youth mental health treatment. A few children and youth with severe mental health needs occasionally have to leave the community and travel to Whitehorse or out of Territory for treatment. This can be a very difficult adjustment, as they may go from a school of ten students to one that has as many as several hundred students. These students need supports to help them transition and succeed in their new environments. An important consideration is whether students would be better served by putting resources into the community so they can remain with their families and friends. While recognizing challenges of having many small communities, some service provider participants believe people would be more likely to seek child and youth mental health services if services were available in their own communities.

Another geographic consideration is the impact of Yukon's long winters. While the lakes, parks and wilderness terrain provide many opportunities in the summer and fall to enjoy the outdoors, youth and family members spoke of winters being "really hard", cold, and long where the four months of darkness negatively affects many people. Particular challenges were discussed because of the periods where Yukon experiences long periods of darkness in winter and long hours of daylight in summer.

Cultural Characteristics

There were some very positive aspects reported about Yukon culture, which supports an active lifestyle with lots of opportunities for outdoor activities. The community of Whitehorse was praised in terms of offering youth a multitude of activities for families.

Participants from Yukon describe the Yukon lifestyle as placing significant emphasis on physical fitness, but less emphasis on mental health. There was frequent mention of a pervasive 'frontier mentality' in Yukon that encourages a macho attitude that can foster stigma and discourage help seeking for mental health problems and disorders. The same mentality was described as promoting a "work hard, play hard, drink hard" approach to life. Several policy advisors described a culture that celebrates drinking without recognizing its dark side that results in significant impacts on health and high costs to the health and social care system. The Yukon Territory was described as having the highest rates of alcohol per capita use in Canada.

Other pervasive cultural considerations are the legacies of Residential School policies that have resulted in long-lasting emotional, mental and spiritual harm to many First Nations communities, according to participants. These legacies also contribute to lack of trust of government by many First nations people. This can prevent families from seeking help because of fear that their children will be taken away. When services are sought, the lingering effects of residential schools can also impact treatment. For example, one First Nation family member spoke about discomfort with providers writing down notes as she spoke, and another described experiences of post-traumatic stress when entering schools or other large institutions.

The lack of trust can also go both ways. One participant spoke about insensitivity by those who do not understand the cultural devastation that has resulted from residential school policies. Lack of understanding can result in judgments about behaviours that are attempts to cope with devastation and chaos that have resulted in families and communities. Furthermore, these judgments can impede effective service delivery to youth and families when they are most in need, such as when a member of the community dies.

Several First Nation and policy advisor participants commented that policies wherein young people are expected to leave their families and travel to other communities for care are disrespectful of these legacies. Furthermore, treating youth in insolation without addressing family and community needs was seen to offer little more than a Band-Aid solution when a more comprehensive approach is required.

One policy advisor emphasized the need for an open dialogue to encourage a more culturally sensitive understanding of community needs. Other policy advisors and service providers suggested a need to attend to deficits in the area of parenting skills among some First Nations families as a result of the residential school experience and its legacies.

Several First Nations participants stressed the healing potential of culturally-based programs such as Jackson Lake camp in the summer, or sewing or beading circles where traditional First Nation practices are foundational. First Nation youth and family member participants similarly described the importance of "going out on the land" with extended family members and elders as an opportunity where children can learn about their heritage and gain skills. The importance of connections across the lifespan and of adopting an approach that stresses wellness for the whole family are particular features of First Nations culture that are built into the programming for children and youth at Kwanlin Dun First Nation.

Some policy makers suggested there is a serious need to address a pervasive sense of hopelessness that exists for youth throughout rural Yukon who feel caught in a world where climate change is threatening traditional lifestyles and Elders are dying without passing on traditional knowledge. This leaves many First Nations youth feeling confused about their futures and about to what they themselves should be aspiring.

Population Characteristics

Policy advisors described the distribution of population economic status, geography, culture and health status, as being clustered at two 'poles,' rather than normally distributed. Participants described a high median income that is mostly enjoyed by a more advantaged, non-native population located in Whitehorse, and a less-advantaged population in the outside communities. This divide in the distribution was described as affecting overall health status, literacy rates and opportunities for First Nations compared with non-First Nations residence.

In terms of population health status and service needs, policy advisors spoke about a critical need for suicide prevention and intervention, crisis services and mental health care in rural communities. Several participants also explained that the needs of rural communities are not uniform. For example, some communities have a greater need for child protection services, while others have more challenges with addictions.

In Whitehorse, different concerns were discussed. Policy advisors felt that most existing mental health services were geared to children and youth with serious mental disorders, but that there is a large population of children and youth with more moderate mental illness for which no services are available.

Several policy advisors also felt that there is a higher prevalence of particular mental disorders such as Attention Deficit Hyperactivity Disorder, Seasonal Affective Disorder, Post Traumatic Stress Disorder and Substance Use Disorders in Yukon than in other Canadian jurisdictions. Shortages of affordable housing that result in precarious housing for youth and young adults were also described as a serious issue for youth with mental disorders.

Other considerations related to the small population size. One policy advisor viewed this as having a positive impact on service delivery in terms of being able to be innovative and responsive to needs of individual youth and families. At the same time, a small population means a smaller human resource pool. This has negative implications for the ability to provide specialist services.

Political Characteristics

Several participants believe that having a small population base can lead to a more political environment for decision-making in Yukon compared with larger jurisdictions. The general public was seen to have closer proximity to Ministers and Assistant Deputy Ministers, which makes it easier to identify which politicians and senior bureaucrats to target in lobbying efforts. This close political climate contributes to what was described as a culture of risk-aversion within government. It can also mean that staff members are wary of speaking up when the government is such a significant employer.

A number of concerns were also raised about the ability to mobilize political will to support implementation of a revised Child and Youth Mental Health Framework. Several participants felt that mental health services have traditionally been seen as a low priority on the government agenda. As an example, participants pointed to the facilities where the services are delivered, which have been identified as being in need of replacement for many years. At the same time, some participants felt that mental health might be starting to receive higher priority at the political level at the current time.

Additional concerns were raised about the even lower priority given to child and youth mental health, which is often seen as an "add on" to mental health services, even though the importance of early intervention for young people is well recognized. Some participants suggested that families could play a key role in advocating for implementation of the Framework; family advocacy was described as being influential in the past for Yukon children and youth with autism spectrum disorders.

Governance

From a governance perspective, there appear to be important policy legacies that shape mental health care in the Yukon. Historically, the federal government provided mental health care delivery to the territory. In 1997, the Federal government devolved the health transfer to the Territorial government. This affected mental health care delivery as well as the nursing stations within the territory. Key informants described how the legacies of a highly biomedical delivery model continue to shape mental health services and care delivery in the nursing stations. One key informant suggested that any effort to integrate mental health care into nursing stations would be extremely difficult due to these legacies.

A further consideration is that the actual transfer of responsibility to the Territorial government took 13 to 14 years. According to one participant, other areas of Health and Social Services expanded over that period, but funding for mental health services was frozen until the transfer was completed. This has resulted in a legacy of underfunding to Mental Health Services. Furthermore, since many Territorial programs for children, youth and families were on the social services side of the department of Health and Social Services, Mental Health Services was left "adrift" in the Health Division, with little voice following the transfer to the territorial government. One policy advisor suggested that these legacies contribute to challenges in coordinating mental health services with other social services.

Disparities in access to child and youth mental health services also arise due to differences in governance across the 14 First Nations communities in the Yukon, 11 of which are self-governing. The Territorial government has responsibility for health services unless the First Nation draws down those health services. As a result there can be significant differences in needs across First Nations communities and there is no interest group that speaks on behalf of all communities.

According to Kwanlin Dun First Nation officials, an agreement exists with the Territorial government that enables the First Nation to provide community services and physician services to First Nations peoples through a nursing station and health centre. Other First

Nations in Yukon do not offer these services and instead mental health care and nursing services are under Yukon government jurisdiction.

Economic Characteristics

A recurring theme was the complexity of funding sources that arise because of the many health and social considerations that impact the mental health of children and families, as well as the complex governance arrangements described above.

Funding sources include federal transfer payments to the Yukon department of Finance, approximately 30% of which goes to healthcare. There is also project-specific funding from the federal government (including a tri-territorial Mental Health First Aid research project), recoveries from other provinces for services provided to their residents within Yukon; funding from Indian and Northern Affairs Canada (INAC) for providing services for children and care on their behalf. The latter is based on volume and activity and recovers the non-medical costs for status First Nations children that are in care. Prescription drug and some travel costs may also be recovered from Non-Insured Health Benefits (NIHB) for status children.

Policy advisor participants described a pattern where the pursuit of temporary funding as it becomes available for different programs has resulted in imbalances with respect to the expansion of different areas within Health and Social Services and other agencies. For example, in the late 1990's there was political support to encourage partnerships to provide services, which expanded rapidly. The hope is that the framework will serve as a blueprint for more coherent planning processes in the future.

Concerns about inequities were also raised because of different funding arrangements for First Nations peoples through the non-insured benefits and other funding arrangements for Metis people.

Participants also spoke about the economic realities in some rural communities where work is seasonal and unemployment is high, making it difficult to make a living and support a family. Family member participants also spoke about some services being unaffordable, such as hourly fees for private counseling. They also pointed to significant transportation costs, child care and time off work to attend appointments for their children when care is not offered within their communities. There is a belief among some service providers that the wealthy in the province have better and quicker access to mental health services being offered by the government.

Finally, there is growing concern about sustainability of government budgets. There is strong political pressure to cut costs and stay within existing budgets, with no new money available to support changes associated with the Child and Youth Mental Health and Addictions Framework. Participants described the potential to free up resources within the system through better case management and eliminating silos and that these may be used to support other changes arising from the framework.

3.2 Feedback on Current Programs

Our analysis of the interview and focus group data from Yukon participants identified the following common themes that applied across the categories of 'What's Working Well', 'Problems and Challenges' and 'Suggestions for Improvement:

- Access
- Information-Sharing, Coordination and Collaboration
- Nature and Availability of Services

- Support for Families
- Stigma
- Culture
- Competencies and Training
- School and Justice-Related Themes
- Governance and Leadership
- Resources

Here we integrate the findings listed in the tables to provide an overview of what was heard.

Access

A major concern of all types of participants was the limited access to child mental health services, particularly in rural communities outside of Whitehorse and that improving access in these communities is a high priority. Although youth and family member participants appreciated the use of telehealth approaches and many participants appreciated the services being provided in Whitehorse by the visiting child and youth psychiatrist from outside the territory, limited access in rural communities was frequently mentioned as a concern. Participants mentioned the lack of crisis services, long delays to see providers, and infrequent visits by counsellors, which were not seen as adequate to meet the service needs of youth and families. Family members and youth also complained about the costs, treatment delays and lack of follow up support associated with travel to receive services located in Whitehorse (for those who live in other communities), or out of Territory.

Several suggestions to improve access to service in rural communities were made. These include offering more frequent visits from counsellors located in Whitehorse or other communities; expanding the use of Skype or telehealth; and encouraging service providers to reside in each community. The latter approach was seen as desirable because it could offer more immediate access to care when required and could be facilitated by spousal hires or housing assistance. One family member participant encouraged adopting creative approaches to service delivery. This could include drop-in access at a community storefront centre that could reduce stigma and improve coordination by offering 'one-stop shopping'. Activities such as Boy and Girls clubs were also seen as potential doorways to accessing services in small communities. Workers in these community organizations could be trained to use a common brief intake-screening tool and have access to a resource directory to help guide youth and families to the services they need. Participants also called for more concerted efforts to build trust between the Yukon Government and First Nations communities. This could provide a foundation that might enhance people's willingness to seek services. Flexible outreach approaches rather than office visits for youth and families in First Nations communities were also supported.

A serious a gap in services for young people with moderate mental health problems, such as clinical depression and anxiety disorders was also pointed to by several policy makers and family members during the interviews. Some participants suggested that diagnostic criteria for mental disorders were being applied too strictly. This could prohibit youth from accessing support, prevention and counseling services that might be helpful to them.

Information-Sharing, Coordination and Collaboration

Family and youth participants spoke about the need for more information about how to access services, what to expect and how families could be supportive of young people with mental disorders. Family members requested the creation of a local number that they could call for immediate crisis support. They also called for trained navigators who could help them access needed services across the system. A First Nations System Navigator was also suggested. Other

suggestions included developing a resource directory to illustrate and explain how to access the full range of services, and establishing a Parent Resource Centre in each community. Such a centre could assist with system navigation and provide treatment information to support family members in caring for young people with mental disorders.

Many participants also pointed to poor communication, coordination and collaboration across service organizations. This can result in youth falling through the cracks between services. In some case treatment delays were reported to range from many months to more than a year. There were several calls for senior leadership to tackle administrative, philosophical and turf considerations that were at the root of this issue. One participant felt strongly that professional regulations about privacy were being used to inhibit information sharing in order to protect turf, at the expense of the well being of children and youth. The participant urged senior leaders to initiate an open discussion on the topic of professional ethics and privacy and send a clear message that information must be shared across departments or agencies for the benefit of the youth and family as a condition of employment.

Several policy advisor participants also called for leaders within Health and Social Services to foster an environment of joint planning and a spirit of collaboration. One service provider suggested that a "Champion of Connections" position be created to spearhead the operationalization of new ways of working together. Other participants felt that enhanced coordination and information-sharing should be structurally embedded into service delivery through revised information sharing agreements, protocols, guidelines, mechanisms and legislation. Furthermore, these changes could be supported through the use of standardized forms, referrals and treatment plans and a centralized case management system to create a common, streamlined intake process and data set. Other suggestions included collaborative case conferences, the formalization of case management and accountabilities and holding interagency meetings in Whitehorse, as is done in the outside communities.

Nature and Availability of Services

We also heard strong praise for efforts to move 'upstream' to promote child and youth mental health and recommendations to expand these efforts. Participants pointed to pre-and post-natal programming to identify at-risk families, and school-based mental health promotion, mental health literacy and socio-emotional learning programs. The work and programming offered by the Child Development Centre and the Youth Achievement Centre received positive feedback. One participant called for the establishment of a single, coordinated mental health prevention and early identification program in all communities rather than multiple, independent efforts by different organizations. The Youth Sexual Health Conference was also seen as an effective mental health promotion activity that addressed sexuality, alcohol and drugs and leadership development among First Nations youth.

Youth and family members also spoke about the dedication of individual health care providers who helped them through difficult times and played an essential role in sharing needed information. There was also appreciation of a variety of treatment approaches including psychiatric specialist services, mental health counseling and assessments, visits by CATS counsellors to the communities and the restorative and relationship-based approaches used in Residential Youth Treatment Services. Alternative education options and strong linkages between schools and the justice system also received positive feedback.

In addition to what was working well, we heard a number of problems and suggestions of way to improve services. A common

suggestion was that mental health programming for children and youth should be broadened to place greater emphasis on mental health promotion and prevention. Youth and family members also suggested that treatment approaches were too narrowly focused on medication and should be expanded to teach coping skills and to take a more comprehensive approach to meeting the multiple needs of young people with mental health problems and disorders. Some service providers also recommended more involvement by youth and families in care decisions. First Nations service providers felt that the abstinence approach adopted by Alcohol and Drug Services was too extreme and prevented help-seeking by many First Nations youth who might otherwise benefit from information and support until they were ready for abstinence.

There was also recognition of the need to provide more affordable housing options and to increase availability of child and youth mental health beds in hospitals as well as transitional and post-treatment beds.

Support for Families

Many family member and policy advisor participants identified the need to better support families through parenting skills programs, respite for families and services for siblings of youth with mental disorders. While the Healthy Families program received widespread praise, several service providers did not understand why it was not being offered in rural communities. One policy advisor suggested that a more coordinated and consistent approach is needed when working with high-risk families. There was a suggestion to adopt a family approach to working with youth in Alcohol and Drug Services. Families were concerned about substantial out-of-pocket costs associated with some treatments and the cost of travel to treatment when required. Families also were upset by legislation or care approaches that prohibit their involvement in the young person's care.

Stigma

Stigma associated with the use of mental health or alcohol and drug services was described as being very common within Yukon, with heightened concerns in First Nations communities. Service providers suggested that the practice of having counsellors visit small communities was particularly stigmatizing, because everyone knew the purpose of the visit. Youth, families and service providers suggested that stigma reduction efforts are needed and youth participants indicated that they are eager to be involved in anti-stigma efforts.

Culture

Culturally appropriate services for First Nations youth, such as the Jackson Lake Camp, mentoring programs by Elders and efforts to incorporate cultural influences in existing mainstream programs for children and youth were highly praised by representatives of all participant perspectives. A service provider participant called for collaborative efforts by mainstream providers and First Nations communities to develop better understanding of traditional cultural practices and to develop ways to expand upon medical and diagnostic approaches. One policy advisor suggested that the Framework should have a First Nations cultural foundation and that First Nations communities need to be engaged in efforts to implement the Framework. One First Nations service provider suggested that parenting programs be made available to all families in First Nations communities to improve parenting skills, using a non-stigmatizing approach. Some service provider and policy advisor participants felt strongly that a residential program for children and youth in care is needed within Yukon, so they do not have to be sent out of the Territory for treatment.

Competencies and Training

Competency development with respect to child and youth mental

health counseling, addiction services, concurrent disorders and crisis management was identified as a common need across Health and Social Services, private providers and other agencies. A particular need for training in the area of concurrent mental health and addictions problems for young people was identified, as well as training that was specific to supporting families and young people across different stages of the age span. Participants also raised concerns about inconsistent provider training in the areas of neurodevelopmental, autism spectrum and fetal alcohol syndrome disorders. A common approach to training across departments and agencies was viewed as a way to develop a common approach to care, improve service provision, referrals and facilitate collaboration across service providers. Participants suggested that this training should also be offered to teachers, school staff, coaches and others who work with children and youth. It can also be used to address specific training deficits with respect to child and youth mental health and addictions for nurses working in hospital and rural family physicians. Other suggestions to optimize use of existing human resources included establishing a child and youth team within Mental Health Services; comparing mental health staffing in Yukon with other jurisdictions; and developing a regulatory framework for psychologists.

School and Justice-Related Themes

Family member participants generally supported the expansion of school based mental health counseling and social-emotional learning programs, but wanted to know more about them. School administrators complained of having to scramble to find and coordinate services for students in crisis. Policy advisors also called for increased collaboration between the departments of Health and Social Services and Education to provide professional support and training for school guidance counsellors and mental health counsellors within schools. This could help to improve mental health competencies among school staff and foster collaboration. Similarly, collaboration between Mental Health Services and Youth Justice could help to overcome perceived inconsistencies in approach and foster mutual understanding.

Interviews conducted with youth with mental disorders who are currently being held within correctional facilities pointed to counseling services and opportunities to continue their school studies as being very beneficial. First Nations youth were particularly grateful for opportunities to have visits and spend time preparing meals with visiting Elders. However, these participants also shared alarming stories about being taunted by guards, experiencing frequent solitary confinement, and not receiving medications normally prescribed to them by psychiatrists outside the facility. These youth urged creation of more cultural, mentoring and physical activities within First Nations communities to help keep youth out of trouble.

Governance and Leadership

The Family and Children's Services Act was seen as instrumental in enabling more family-centred services for First Nations families. The emphasis placed on evidence-based approaches and efforts to collaborate across departments, agencies and First Nations communities were also praised.

Participants pointed to a number of administrative barriers that hamper effective collaboration and planning across programs. For example, several policy advisors questioned the effectiveness of services provided by contracted agencies. They also described difficult relations between some nursing stations and First Nations communities that can hamper effective service provision to children and youth in rural communities. Several service providers were upset about inconsistency in offering support to families outside of Whitehorse through the Healthy Families Program. Participants suggested that proactive leadership "from the top" is required to support more coordinated approaches and improved collaboration

in service delivery. Specific suggestions included establishing a single Director for Mental Health and Alcohol and Drug Services, combining prevention efforts across these and all other areas of the department, and creating a youth and family assessment area within the new Alcohol and Drug Services facility that could accept referrals from different organizations, programs, schools and the justice system.

Resources

Many service providers and policy advisors felt that insufficient resources are allocated to mental health services, with particular shortfalls for child and youth mental health. One participant saw this resource shortage as prohibiting Mental Health Services from taking a leadership role in case coordination for children and youth and called for collaborative service delivery as a way to free up system resources. Many service providers and policy advisors prioritized the need to address imbalances in distribution of resources between Whitehorse and rural communities and also discussed the need for more supportive and affordable housing and shelter options as a way to promote recovery for young people with mental disorders. A review of the distribution of existing resources could set the stage for an action plan to implement the framework.

3.3 Phase 2: Learning From Comparator Jurisdictions

Table 3.1 lists the comparator jurisdictions from which lessons for Yukon were gathered, the relevant framework (Manitoba, Alberta, Ontario and New Zealand) or evidence-based programming considered (British Columbia, Hawaii, Alaska, and Norway), and the corresponding Yukon characteristics.

Findings by Jurisdiction

Document review and interviews with stakeholders from selected comparator jurisdictions yielded a great deal of relevant information for the content and implementation of a child and youth mental health framework for Yukon. This section of the report provides a brief overview of framework and program content, implementation lessons and key take-home messages from the selected comparator jurisdictions.

Manitoba

The Manitoba interviews focused on the *Healthy Child Manitoba* (HCM) (Government of Manitoba, n.d.) approach to working together across all government departments whose policies affect the health and well-being of children, youth and families. This approach was described as a key enabler of the development of child and youth mental health policies in the Manitoba context. The HCM strategy was implemented in 2000 and later supported by the Healthy Child Manitoba Act in 2007.

HCM is a cross-departmental prevention strategy built upon a child-centered public policy framework that integrates economic and social justice. The Healthy Child Committee of Cabinet (HCCC), composed of representatives of 10 governmental departments involved in policies that affect children, youth and families leads the HCM strategy. There is a corresponding Committee of Deputy Ministers and 27 Parent-Child Coalitions of citizens from across the province. Members of Parent-Child Coalitions make presentations to the HCM Cabinet Committee and Members of the Deputies' Committee sit in on these meetings. This set of structures facilitates more rapid development of comprehensive policies that are rooted in community needs to promote health and well-being of children, youth and families.

Table 3.1
Selected Comparator Jurisdictions

Comparator Jurisdictions with Frameworks (n=4)		
Jurisdiction	**Framework**	**Yukon Salient Characteristic**
Manitoba	Healthy Child Manitoba	• Structure/Organization • Socio-political • Geographic • Cultural
Alberta	Creating Connections	• Structure/Organization • Service/Clinical Approaches • Socio-political • Cultural
Ontario	A Shared Responsibility – A Policy Framework for Child and Youth Mental Health in Ontario	• Structure/Organization • Service/Clinical Approaches • Socio-political • Governance
New Zealand	Te Kokiri the Mental health and addictions plan 2006-2015	• Cultural • Governance • Structure/Organization
Comparator Jurisdictions with Innovative Programming (n=4)		
Jurisdiction	**Innovative Program**	**Yukon Salient Characteristic**
B.C.	Rapid Access to Consultative Expertise (RACE)	• Geographic • Service/Clinical Approaches
Hawaii	Child and Adolescent Mental Health Division (CAMHD) Hawaii Families as Allies	• Governance • Service/Clinical Approaches • Structure/Organization
Alaska	Southcentral Foundation's NUKA Model	• Structure/Organization • Population • Cultural
Norway	Family House	• Geographic • Structure/Organization • Service/Clinical Approaches

Key enablers to the establishment of the HCM Committee of Cabinet were top-level political leadership, supported by outside pressure, having an inside engine and sufficient resources. This approach was driven by a Minister, with the buy-in of the Premier and has continuing high-level support as a result of recognition of immediate benefits derived from the approach. The Premier appoints all Ministers to the HCM Cabinet Committee. Leadership of each Committee rotates and is never from the same department in order to avoid the inadvertent creation of a 'Super-Ministry' model. The latter was rejected because of concerns that every department needed to have a stake in a jointly led process in which participants are jointly responsible. The model was initiated without being legislated, but subsequent legislation set forth evaluation guidelines for all HCM programs and facilitated research on effectiveness and outcomes for children and youth in Manitoba. In this way the legislation was a key enabler for sustainability of the model.

The Manitoba model also states that new approaches and programs are established equitably in northern communities, isolated areas and First Nations communities. This requires building in funding upfront for training additional staff due to higher turnover in northern than in southern communities (typically 4:1). Wraparound approaches (Brown & Loughlin, 2002; Burns & Goldman, 1999; Burns et al., 2000; DeBicki, 2009; Winters & Metz, 2009)are also used to meet the needs of children and youth with complex behavioural issues.

Key informants described HCM as a highly effective model that provides top-level support in dealing with conflicts over responsibility for delivering services at the front line and in overcoming structural barriers across departments. The multi-department approach is thought to provide a stronger, more representative voice at the Cabinet table for policies and frameworks than would otherwise originate from a single department.

Within the context of the HCM infrastructure, there is a key and specific mental health policy branch that provides strategic and policy direction to the province. This Mental Health and Spiritual Care Branch is situated in the Health, Healthy Living and Seniors Department, which is a partner department of the HCM infrastructure. At the time of the interview, the mental health policy branch was leading the development of a population-level Framework for Mental Health and Well-being for Children and Youth. Also, in 2008 the provincial Suicide Prevention Strategy was released, with a focus on aboriginal children and youth, whose development was led by the Mental Health and Spiritual Care Branch (Manitoba Healthy Living, 2008). Informants felt that having the HCM structures in place facilitated the development and raised the profile of both of these policy documents and that both will have signatures of 10 Ministers once released.

HCM's has a strong commitment to the use of evidence-based policy, monitoring, evaluation and programming. HCM evidence-based programming includes, among others, wraparound approaches for children and youth with complex behavioural issues; parenting support programs to support positive parenting; and home visiting program to support at-risk families with preschoolers. Evaluation was seen to be paramount to demonstrate benefits. One key informant suggested that evaluation should be mandated in all programs.

The main message from the Manitoba experience is that structures and leadership at the highest political levels are essential to successful development of child and youth mental health policy and programming. The model has low upfront costs (e.g through use of secondments of key staff), but doe require a significant commitment by Ministers and Deputy Ministers from multiple departments. In the long run the model is seen to be cost effective because it moves decisions forward more quickly and effectively. It

also saves time at the community level in obtaining access to services for individual children and youth. In summary, key informants felt the HCM model could work extremely well in the Yukon and could be implemented quickly (in less than a year). Legislation was seen to be an important enabler.

Alberta

Creating Connections is Alberta's integrated addictions and mental health strategy that spans all age groups (Government of Alberta, 2011). Its strategy document identifies five strategic directions and provides an Action Plan, which is supported by an Executive Steering Committee that meets regularly.

The second of Creating Connections' five strategic directions is dedicated to children, youth and families and is supplemented with additional implications from the other four strategic directions. In January 2014, Ministers of Health and Human Services, Alberta Health Services and NGOs met to create a Mental Health Action Plan specifically for youth. In addition, a meeting involving Alberta Health Services, NGOs, front line child welfare workers, and other ministries took place in early 2014 to seek out input and feedback on service gaps and determine key areas of focus to begin to address these gaps and set realistic goals for 2014.

The development of Creating Connections was a collaborative process involving multiple stakeholder groups. Considerable time was spent in the initial stages to develop a common set of values as a basis for the strategy. Ministries whose services directly or indirectly impact health outcomes for children, families and youth, actively worked together throughout the strategy's development. Ongoing collaboration involving these ministries is multi-tiered and structured so that ministries meet on a regular basis. This includes ongoing meetings between Ministry staff and NGOs, service providers and service users to hear all perspectives and input that is now continuing throughout the implementation process. Early, meaningful and ongoing engagement with Aboriginal stakeholders has also been a priority and Alberta's Aboriginal Relations Ministry has also been involved in development of the strategy. A Steering Committee meets every six weeks and all services provided are reviewed using a rural/remote checklist developed by the Aboriginal Relations Ministry.

This structured ongoing collaboration at multiple levels has been a key enabler by providing a forum for ongoing discussion about the needs of the different client groups served, as well as discussion of what's missing. The province has also dedicated $5 million to Human Services to enhance mental health services and $1 million in funding for training to raise mental health literacy of human services providers such as Foster Parents, staff at group homes, police, and social workers through the Mental Health First Aid program (MHCC).

A further enabler of collaboration across disciplines and stakeholder groups is common training, common language and buy-in on high level goals from everyone at the table. Having well-defined roles and openness to multiple evidence based treatment approaches that meet professional standards of care were also identified as important precursors for successful collaboration. Effective collaboration is also facilitated when participants share the view that no single treatment option will work for all needs/populations and that different treatments approaches can help to meet the varying population needs.

Ontario

*A Shared Responsibility - Ontario's Policy Framework for Child and Youth Mental Healt*h was released in 2006 (Ministry of Children and Youth Services, 2006). It described child and youth mental health

needs across a continuum of mental health promotion, illness prevention, early identification and intervention, community support and treatment programs. Framework goals included collaboration, accessibility, responsiveness and accountability. The framework explicitly acknowledges the need for a systems approach and provides a vision for child and youth mental health.

Several ministries (Ministry of Children and Youth Services (MCYS), Ministry of Health and Long-Term Care (MOHLTC) Ministry of Education (EDU), Ministry of Community and Social Services (MCSS), Ministry of Community Safety and Correctional Services (MCSCS) Ministry of Attorney General (MAG), and community partners participated in the year-long framework development process. The framework was developed using extensive engagement/buy-in approaches involving family members and the public to meet their needs and place them at the centre. In addition, mental health experts were consulted and an extensive inter-jurisdictional literature review was undertaken.

On June 22, 2011, the Ontario government announced a new comprehensive mental health strategy that spanned the adult and child and youth sectors called *Open Minds, Healthy Minds, a Comprehensive Mental Health and Addictions Strategy* (strategy) (Ontario Government, 2011). The goal of the Strategy is to improve mental health and well-being for all Ontarians, and create more coordinated, responsive, client-centred mental health and addictions services throughout the province. The first three years of the strategy, focused on children and youth, which is the focus of this summary. The services and supports implemented as part of the child and youth elements of the Strategy focused on three key areas: fast access to high-quality services, early identification and support, and helping vulnerable children and youth with unique needs. To accomplish this, large scale, comprehensive system transformation of the community-based child and youth mental health services system is currently underway (Ontario Ministry of Child and Youth Services, 2011).

Key informants suggested a number of considerations for policy development processes and implementation. First, the process of undertaking inter-ministry consultations and collaboration is time consuming. The Advice to the Yukon is to allow plenty of time to negotiate ongoing support across multiple ministries because broad-based support is essential to successful implementation. In addition, bureaucratic and Ministerial support across three Ministries was necessary in the Ontario context (MOHLTC, MCYS and EDU) as well as support form cabinet and Ministers accountable to Cabinet in order to support successful delivery. Second, political buy-in is required at the highest levels prior to and throughout the implementation process. Third, it is important to invite Aboriginal stakeholders to be part of the earliest stages of framework development and to ask about their interest in partnering in the development of a broader framework that is reflective of the needs of Aboriginal populations and communities. Finally, continued engagement with the public, youth, families, including Aboriginal and Francophone stakeholders, throughout development and implementation processes is an important element in creating political will for reform.

Other strategic considerations discussed by the Ontario participants where that:

- An explicit statement must be made that the framework and the system are built around the needs and children, youth and families.
- It is important to measure outcomes against these needs and at the same time to allow for flexibility in terms of how individual departments achieve outcomes. This flexibility includes allowing for varied approaches and philosophical differences across care

providers as long as professional standards and evidence-based approaches are used.
- Clear accountability and standards also must be clearly stated as part of the policy. It is important to build evaluation objectives, measures and outcomes into the policy along with a clear indication of responsibility for them.

Finally, Ontario informants emphasized that the policy itself is not an end point. Instead it is meant to be a facilitator in the development of programming, services and supports to meet the needs of children, youth and families.

New Zealand

New Zealand's first mental health framework for children and youth, *New Futures*, was released in 1998 (Ministry of Health, 1998). This was preceded by a national service framework that spells out core mental health service requirements in detail (New Zealand Government). Since then another national framework, include Te Kokiri was developed for the mental health system as a whole (Minister of Health, 2006) and, Rising to the Challenge (Ministry of Health, 2012) was developed as an updated framework for children and youth mental health.

Key principles that run throughout all of New Zealand's mental health strategies and plans are that they must be recovery focused, client-centered and culturally responsive [New Zealand Key Informant]. The objective of the initial child and youth strategy (New Futures) was to address gaps in secondary and tertiary care for children and youth with severe mental disorders. In Rising to the Challenge, the more recent focus has been to expand upon these efforts to include children and youth with more moderate needs.

New Zealand's approach emphasizes collaboration, working across government departments, including through a cross-agency Youth Mental Health Project, and adopting a coordinated response to the needs of children in care. In rural communities, delivery is embedded within the community. Because the funding model lacks rural-specific weighting, the full range of services cannot be delivered in every rural community. Instead, the focus is on core diagnostic and treatment services (which are required in the national service framework) delivered by local primary care and the NGO sector through collaborative interdisciplinary teams, with specialty support by tele- and video-conferencing and occasional visits from specialist services.

The New Zealand Founding Charter creates an expectation that all mainstream services be culturally competent (DeSouza, 2008). This means that services must provide care that reflects "diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural and linguistic needs" (Betancourt et al., 2002, p. v.) This requires mandatory cultural training for all staff as a core competency. All District Health Boards and larger services also have cultural advisors (often Elders) who provide advice on cultural issues. The child and youth framework adopts a "By Maori, for Maori," approach to offering culturally-responsive care in rural indigenous communities. This approach has been found to be the most successful approach to support delivery of indigenous services. Coordinated training is provided to Maori practitioners, typically social workers, nurses and occupational therapists through the Maori Workforce Development Centre. Informants stressed the importance of planning for significant turnover in rural indigenous communities by training extra workers so that continuity can be maintained if workers leave the communities.

In the New Zealand experience, a good evidence-base for programming is important but not the only requirement for success. While key informants recognized the need for evaluation and research, they felt more work needed to be done in these areas in

New Zealand. What has been essential to their success has been developing good working relationships across levels of government, and between governments and community NGOs. More top-down approaches were used in the past, but not found to be successful.

Sustained political will and having the core national framework that spells out service requirements were identified as key enablers and essential to successes in New Zealand context. Informants also pointed to the importance of specific structures (Youth Mental Health Project) and programming (wraparound care) to support cross-departmental collaboration and coordinated responses to meet the needs of children and youth.

Norway

Our literature review and key informant interviews focused on Norway's Family House model (Adolfsen & Martinussen, 2010), which is an innovative model of care that emphasizes easy access to collaborative and integrated delivery of face-to-face services. Family House was developed to address unmet needs of "at risk" families by providing an integrated and interdisciplinary approach to service provision. Based on the Swedish "Family Centre" model, Norway's Family House model includes services across the spectrum; promotion, prevention and treatment services are all provided in a single facility and delivered in an integrated and accessible manner. Typically the Family House model includes: a maternal/child health clinic; pregnancy care; open kindergarten; and, preventative child protection as well as pedagogical psychological services. The objectives of the Family House model include providing universal health promotion and prevention services and early identification and support for high-risk families.

In 2002, Family House was piloted in six communities selected for their representation of diverse geographic regions across Norway. Positive feedback from pilot communities led to additional (and eventually permanent) funding to provide ongoing programming and expansion of the Family House model. There are now 150 Family House entities in approximately 1/3 of Norway's 428 communities. Family House is currently recommended as the preferred model of service and there are plans underway to develop policy to support expansion of Family House across Norway.

Flexible implementation of the model allows adjustments in programming to match needs of community and local conditions. Identified benefits include ease of access to services for families, increased participation in programming, and inter-disciplinary collaboration. Importantly, the family, rather than the individual child, is the essential entity in delivery of Family House supports and services. Political support was identified as a key factor in the development of Family House within a given community.

Implementation advice stressed the importance of establishing a connection to a research environment such as a university research centre in order to facilitate research and evaluation. It was also recommended that decision-makers and management ensure ongoing evaluation is embedded in implementation plans.

In addition to the Family House model, key informants discussed Norway's web-based capacity-building and support program known as Crisis-net North for their rural and northern care providers because of its relevance to the Yukon context. Norway's northern climate, physical geography and population distribution are similar to those found in Yukon. Norway has many small communities, plus a concentrated population in its capital city. Norway emphasizes the use of technology and formal communication agreements between small communities in rural and remote areas to build capacity and provide support to rural/remote care providers. Norway's Crisis-net North program uses a webinar format on a secure internet service to deliver psychosocial education/support using annonymized client

scenarios. This model of providing support to health and human service providers may be of interest to Yukon decision makers as the program is easy to implement and requires few additional resources. A link to e-learning program modules can also be made available.

Hawaii

Reform of mental health services for children and youth across the state of Hawaii has stressed the importance of partnerships with community as well as interdepartmental and interdisciplinary collaboration (Nakamura et al., 2011). Examples include the longstanding partnership of Child and Adolescent Mental Health Division (CAMHD) with community-based parent support NGO called Hawaii Families as Allies (HFAA) and CAMHD's court-mandated partnership with the Department of Education. These partnerships have been key elements in developing innovative service delivery and expanding services to meet needs of all children, youth and families in Hawaii.

HFAA plays a critical role in supporting families who have children with emotional or behavioural challenges through their education and support programming. Their staff and volunteers reflect Hawaii's diverse ethnic makeup including First Nations populations. These groups have been extensively involved in state-wide reforms in CAMHD. HFAA programming includes the state-wide youth council for mental health called "Hawaii Youth Helping Youth" whose membership is open to youth with lived experience as well as their siblings and friends. Leveraging the support of youth, families and communities through HFAA is integral to service delivery reform and ongoing responsiveness to youth, family and community needs. A key message from the Hawaii informants is the need for meaningful involvement of children, youth and families across all levels of service planning and delivery. For example, partnerships with community-based NGOs like Hawaii Families as Allies; community consultations and meaningful engagement in treatment planning and decision-making are required in order to meet the needs of individual children, youth and families.

Another key message is the importance of maintaining a dedicated focus on children and youth in the delivery of mental health care as their distinct needs and corresponding system responses require a developmental lens and treatment goals that emphasize strengthening families and integrating youth into community life. In addition, culturally based mentorship programs that pair First Nations youth with elders (and may include spiritual elements) can help struggling youth begin to think about their life path.

Hawaii's leadership in evidence-based programming is based in large part on the work of the state's interdisciplinary committee on evidence-based treatments (known as Evidence Based or EBS Committee) that has been ongoing for the past 10 years. EBS Committee work has led to the development and implementation of a state-wide initiative on practice guidelines and has enhanced internal capacity for ongoing review of methods, procedures and practice guidelines. The EBS Committee work stresses the importance of having review mechanisms in place for monitoring and evaluation of the implementation process and the flexibility to adjust based on feedback. This flexibility in implementation keeps the focus on quality and responsiveness in programming that reflects an ongoing commitment to innovation and quality improvement as part of the vision and mission.

Alaska

This section is largely based on a discussion of Southcentral Foundation (SCF) Nuka System of Care (Galbraith & Eby, 2010). We also briefly discuss two programs of potential interest to Yukon decision-makers: Bring the Kids Home and Family Wellness Warriors.

SCF's Nuka System of Care is a complete health care system created, managed and owned by Alaska Native people. Its holistic approach includes behavioral, dental, medical and traditional services that are informed by Alaska Native values and the principle of self-determination. Alaska Native cultural values inform all aspects of planning and service delivery.

The Nuka System of Care was developed as a result of complete system transformation through innovation and focusing on the key concept of the "customer-owner" that applies to people who are receiving services, and on the concept of relationship-based care. Organizational strategies and processes were developed to support these core concepts. The process of transformation began in the 1980's and included extensive consultations with staff and customers, redefining vision and mission statements, the development of operating principles and the implementation of a transformed system beginning in 2000. Over the years, a strong evidence base has emerged for the Nuka System of Care, demonstrated by improvements across system level and clinical indicators. SCF is now a recognized leader in system transformation.

Informants stressed the following key points with respect to incorporation of evidence-based programming:

- Ensure providers are knowledgeable in evidence-based clinical interventions;
- Create mechanisms for ongoing review of existing programs based on latest evidence;
- Require evidence-based programming to reflect specific population characteristics and needs, such as those of First Nations populations.

Furthermore, where there is a limited evidence base upon which to assess program efficacy for First Nations populations, the advice is to seek research grants and funding to pilot test and evaluate innovative approaches and scale them up broadly if the pilots are found to be successful.

Other lessons from the SCF experience are that meaningful system change takes time, and requires a significant amount of work upfront. Transformation begins with listening to and making central the relationship with the "customer-owner", rather than focusing on the different types of services and supports delivered. Change needs to be driven by customer-owners, and organizational staff, rather than by funding sources. Sustained change requires strong leadership at the top and a common vision, which is reinforced through training and internal professional development. Leaders or champions across the organization are required, as are governance structures and policies that support and reinforce a culture of change and the shared vision and mission. Strong public relations are needed to educate staff and the public about planned changes.

Bring the Kids Home (BTKH) (Alaska Department of Health & Social Services, 2011) is a program developed in 2004 in response to increasing reliance on residential care and drastic increases in out of state placements for treatment of severely emotionally disturbed youth (with Alaska Native youth overrepresented in this population). BTKH planning, capacity development, management and policy changes, and the investment of new resources have contributed substantially to reforming Alaska's behavioral health system of care and improving outcomes for children and youth. Fewer children are now receiving Medicaid funded out-of-state mental health treatment, and new supports are available to children and their families in the community. BTKH is no longer a stand-alone initiative. Instead resources, supports and programming established through the BTKH initiative are now part of standard practices within Behavioral Services.

The Family Wellness Warriors Initiative (FWWI) is a 3-year model for change that features an education and training program for health and human service workers who are regarded within their communities as "natural helpers" (Gottlieb, 2007). FWWI goals are oriented towards building capacity to stop domestic violence, child sexual abuse and child neglect and to promote wellness in Alaska Native communities. The initiative is grounded in cultural practices and values and developed by Alaska Native people. This intensive program requires completion of an application process and on-site lodging. Feedback from participants has been very positive. FWWI has won multiple awards including The National Indian Health Board Regional / Area Impact Award in 2009 for demonstrating a positive impact on the health of Alaska Native families (Southcentral Foundation, 2015).

4.0 Framework Development

The findings discussed in section 3.0 above were used to develop a framework to address the needs of Yukon children, youth and families across the continuum of care and at the same time be feasible in light of Yukon policy considerations including Interests, institutions and ideas. For example, the needs of different interests were taken into account based on what was heard during the stakeholder interviews, the Delphi process with policy advisors and the clinician's workshop. The constraints and opportunities associated with institutional realities were reflected in the analysis of geographic, political, economic, cultural, population and governance characteristics. The core ideas of the framework were shaped by the values of different stakeholder groups, best evidence gathered through literature review, recommended approaches from comparator jurisdictions, suggestions contained in the Evergreen framework and expert opinion. The latter include specific tactics to achieve a comprehensive continuum of services that span promotion, prevention, intervention and ongoing care as well as research and evaluation needs. The lessons from comparator jurisdictions that face similar challenges to Yukon helped in selecting among and augmenting the menu of suggested Evergreen tactics and yielded insights for framework implementation.

In the following sections we summarize the key messages from the various data sources that went into preparing a draft version of the framework. This draft framework was presented for discussion at a policy dialogue of stakeholders. More details on each of the following sources are provided in Appendix C:

- Analysis of salient characteristics,
- Feedback on existing programs
- Common themes from comparator jurisdictions
- Identification of framework objectives
- Clinician's Input
- Feedback from the Policy Dialogue.

4.1 Analysis of Salient Characteristics

The analysis of salient characteristics suggests that geographic, cultural, population, political, economic and governance characteristics all have an influence service delivery in Yukon. Geography, culture, and population were described as having an important influence on mental health and additions needs of children and youth and how services are delivered. Political, economic and governance factors were similarly described as having implications for service delivery, as well as for implementation of the Child and Youth Mental Health and Addictions Framework for the Yukon.

Yukon's geography, culture and population have interrelated impacts on mental health and addictions needs and service delivery. For example, the long dark winters were described as contributing to mental health issues such as seasonal affective disorder (SAD). Former residential school policies were described as contributing to

high rates of suicide, family breakdown and alcohol use in some communities. Furthermore, the associated loss of parenting skills was described as contributing to mental health problems and poorer coping skills among some children and youth in the Yukon. The 'work hard, play hard, drink hard' frontier mentality was seen to contribute to high levels of alcohol use in Yukon. A sense of hopelessness among many First Nations youth was also described.

These influences on mental health and addiction needs are compounded by the impact of geography, culture and population on service delivery. The large distances have resulted in the delivery of infrequent, itinerant care to rural communities. Where services do exist, they are seen to be insufficient to meet the local needs in many rural communities. This means some youth must leave their communities to receive treatment in Whitehorse, which can be disruptive for school, relationships with family, friends and the community.

The politically close environment means that families are able to access local politicians about their concerns more easily than in a larger jurisdiction and may be in a position to advocate for reform. This can help to overcome legacies of limited resources for mental health services. The complexities of funding and governance arrangements means there is a need to ask First Nations how to best implement the framework within each community. Finally, limited resource availability means it is important to capitalize on and use existing resources as effectively as possible.

4.2 Feedback on Existing Programs

The clear priority for family members and youth is to improve access to services and have support in navigating them. Suggestions focused on novel, one-stop shopping approaches offered within communities, and better use of technology. A consistent message was the need to close the gap between rural Yukon and Whitehorse with respect to access to services and meeting the mental health needs of children and youth.

Participants also made suggestions to improve the mental health competencies of health care providers, educators, counsellors and others who work with children and youth to enable counseling and referral to take place within communities. It was also suggested that existing telehealth capacity could be better used to establish virtual teams to take advantage of existing human resources to meet the needs of all communities.

It was also commonly recognized that strong leadership is needed to improve collaboration across departments. Participants suggested that developing a common set of values was the starting point for a shift in culture to work together around the shared objective of helping Yukon children and youth. From these common values, a set of guiding principles could be developed, and a gap analysis for Yukon as a whole and for each community could be the first step in a collaborative planning process. It was suggested that leaders within government should stress the expectation of information-sharing across departments whenever it is in the best interest of the child and family. Ultimately a common Electronic Health Record was seen as necessary to support collaboration across departments and information flow across virtual teams.

There was also support for integrating Mental Health Services and Alcohol and Drug Services, perhaps under a single Director. Improved linkages between mental health, education and youth justice were also called for at the administrative level and in service delivery. A further suggestion was that Health and Social Services and its agencies work with First Nations communities to improve cultural competencies of professionals working with children and youth and to add cultural components to existing programs. In

addition, participants suggested that programs that are currently working well, such as Jackson Lake Camp, mentorship programs and programs for youth to spend time with Elders be expanded.

Policy makers also stressed the need to shift the focus upstream to promote the mental health of children, youth and families and prevent mental disorders wherever possible. There were suggestions for additional parenting skills programs and other mental health promoting activities for First Nations Youth and families.

4.3 Common Themes from Analysis of Comparator Jurisdictions

Framework Content

Informants from Alberta, Manitoba, Ontario and Alaska indicated that the framework should provide a common vision, language, and values to enable buy-in across stakeholders on high-level goals that would encourage collaboration across departments and build broad public support for the Framework.

Many informants also recommended Collaborative approaches to care delivery that involve the primary care, education and NGO sectors. Another common themes was that wherever possible, mental health care should be delivered within the community. There was also strong support for school-based services. Informants from New Zealand, Alaska, Norway and Ontario indicated that specialty support through video and teleconferencing and occasional specialist visits to communities can assist local providers and avoid difficult and costly travel to receive specialty care. As shown in Norway, these technologies can also play a key role in supporting education and training of community-based providers. Case management and wraparound approaches for children and youth with complex needs were also strongly recommended.

Participants made a number of suggestions to develop culturally responsive services for Aboriginal populations. Informants from New Zealand and Alaska suggested that child and youth mental health competency training be offered to Aboriginal people within communities. In New Zealand, the focus was on training nurses, social workers and occupational therapists. In Hawaii, culturally-based mentorship programs for children and youth were also found to be very beneficial. In Southcentral Alaska the Bring the Kids Home program also focused on treating Aboriginal youth within their own communities.

Placing emphasis on prevention, promotion and early identification and offering support for high-risk families were also common themes. In Norway and Hawaii, key approaches were to treat the family as a unit and to adopt a developmental lens.

Framework Implementation

Several common messages about implementation emerged across jurisdictions:

- **Sustained, high-level leadership is essential.**

Leadership is needed at the highest level and must be supported by structures, policies and approaches to facilitate joint working and collaboration across health, social services, justice and education departments. Although informants emphasized that it can take considerable time to build this kind of political buy-in, the time investment was seen as essential in order to move forward effectively. Furthermore, the informants from Southcentral Alaska emphasized that sustained leadership is required to establish a culture of change and to develop strong public relations to educate the public and staff about transformation efforts that may take many years to realize. These efforts will help to support implementation over the long-term.

- **Keep the focus on the needs of children, youth and families.**

The needs of children, youth and families must remain the focus of reform throughout the formation, implementation and evaluation phases of policy development. Extensive public stakeholder consultation and dialogue can be used to reinforce this emphasis. Different approaches to engaging children and families were adopted in different jurisdictions. In the Southcentral Alaska model, clients are viewed as customer-owners of the health syste. In Hawaii, a Family NGO is viewed as a partner in service delivery. In Manitoba, structures were created wherein community groups can interface directly with senior politicians and high level bureaucratic leads on a regular basis.

- **Establish clear accountability for outcomes, but allow for flexibility among evidence-based approaches.**

A third common theme was to also focus on outcomes and develop clear accountability and standards for delivery. At the same time, participants from Ontario, Alberta and New Zealand suggested that there should tolerance for multiple approaches to treatment as long as they are evidence-based and meet professional care standards. In Hawaii, an 'Evidence Based Committee' was established with responsibility to enhance internal capacity in the use of evidence-based guidelines and to ensure evaluation is embedded throughout implementation. The informants from Southcentral Foundation recommended that where evidence is lacking, pilot projects be used to gather context-specific evidence before innovations are implemented on a broad scale. The informant from Norway and Manitoba recommended developing relationships with academic institutions to encourage the development of evidence and evaluation that could support ongoing implementation. Several jurisdictions also made an ongoing commitment to innovation and quality improvement.

- **Take time to establish relationships at the local level.**

Developing good relationships between governments, communities and NGO organizations was found to be extremely helpful. The New Zealand informants explained that a national service framework that spelled out service delivery expectations was important; however, top-down approaches to implementation were not helpful. Instead, success depended on developing effective relationships with local communities to determine best approaches to meet local needs.

- **Engage the Aboriginal population early in the process.**

A fifth theme pertained to engaging the Aboriginal population early in the development of the framework and sustaining that engagement through the implementation and evaluation phases.

- **Framework development is just the beginning.**

The final message from Ontario was that the development of the Framework should not be seen as an end in itself, but rather as just the beginning. The role of the Framework is to facilitate the development of programming and services. Once the framework is developed, just as much attention needs to be placed on implementation considerations.

4.4 Identification of Framework Objectives

Using a modified Delphi approach, policy advisors within Yukon Health and Social Services and Education departments identified a set of key objectives for framework content and use, as well as important implementation considerations.

Objectives for Framework Content:

- **Include higher-level statements of visions/principles and values.** The first objective was that the framework should offer a set of higher-level statements of vision and principles. Working Group members agreed that a subcommittee of the Working Group would propose a set of values for consideration by Policy Dialogue participants.

- **Address the gaps between Whitehorse and rural communities.** The second objective was that the framework should take steps to address the gap between the mental health status of children and youth in Whitehorse compared to rural communities. Delphi participants also wanted the Framework to offer clinical guidance in terms of what should be expected in terms of the range of programming for children and youth with mental disorders. In addition, the Framework should offer a comprehensive continuum of care that includes mental health promotion, prevention, treatment and ongoing care as well as considerations for research and evaluation.

- **Offer clinical guidance and common language.** Delphi participants indicated that the framework should specify the range of services that should be needed to meeting the treatment needs of children and youth in Yukon. This should depend on the development of common definitions of key elements of the mental health and addictions needs of children and youth.

- **Comprehensive Continuum of Care.** Delphi participants also called for a full continuum of care that places emphasis on mental health promotion and prevention services as well as clinical services for treatment.

Objectives For How the Framework Should Be Used

Delphi participants suggest that the framework should:

- **Serve a strategic purpose** in highlighting the importance of addressing the mental health and addictions needs of children and youth in Yukon.
- **Guide strategic and policy planning** as well as in priority setting.
- **Establish the range of services to be offered** and resource needs.
- **Strengthen collaborative processes** across areas and departments within government, First Nation communities and other organizations and providers that deliver programs and services to children and youth in Yukon.

Implementation Considerations:

Delphi participants identified funding and human resource constraints as potential barriers to implementation of the Framework. In addition, there were concerns about capacity within the Department of Health and Social Services and rural communities to support implementation. A final consideration was the need to have a better understanding of First Nations culture in order to support effective implementation of the Framework. Factors that were identified as supporting implementation were having the support of the general population and communities, recent updates to legislation standards for licensing and professional registration the opportunity to take utilize available technologies.

4.5 Clinicians' Input

At the Clinician Workshop, general support emerged from the session about the following needs and considerations for inclusion in the Framework:

- A full continuum of services;
- Culturally-grounded interventions;
- Funding for individuals and agencies;
- Better communication; and
- And easier approaches to finding and choosing services.

Clinician's also had suggestions for general and more specific elements to include in the framework. For example, clinicians felt that it was important that the framework include:

- Mental health literacy and public education;

- Family mental health treatment;
- Stable housing options for youth with serious mental illness;
- Continuing professional education;
- Additional professional resources; and
- An emphasis on early identification.

More specific elements that were suggested by clinicians included 24-hour crisis stabilization, mobile crisis intervention teams, and ready access to specialty consultation.

4.6 Input from Evergreen

Evergreen served as a key 'touchstone' in during the three phases of developing the Yukon Framework as discussed in section 2.0 (See Figure 2). The Yukon framework was designed to be responsive to the territorial context, meet identified needs of stakeholders, and reflect the strategic lessons learned from other jurisdictions. The Yukon framework consists of five components: Common Language, Core Values, Mental Health Needs, Comprehensive Programming, and a Cascading Model of Service Delivery (See Appendix H).

Values

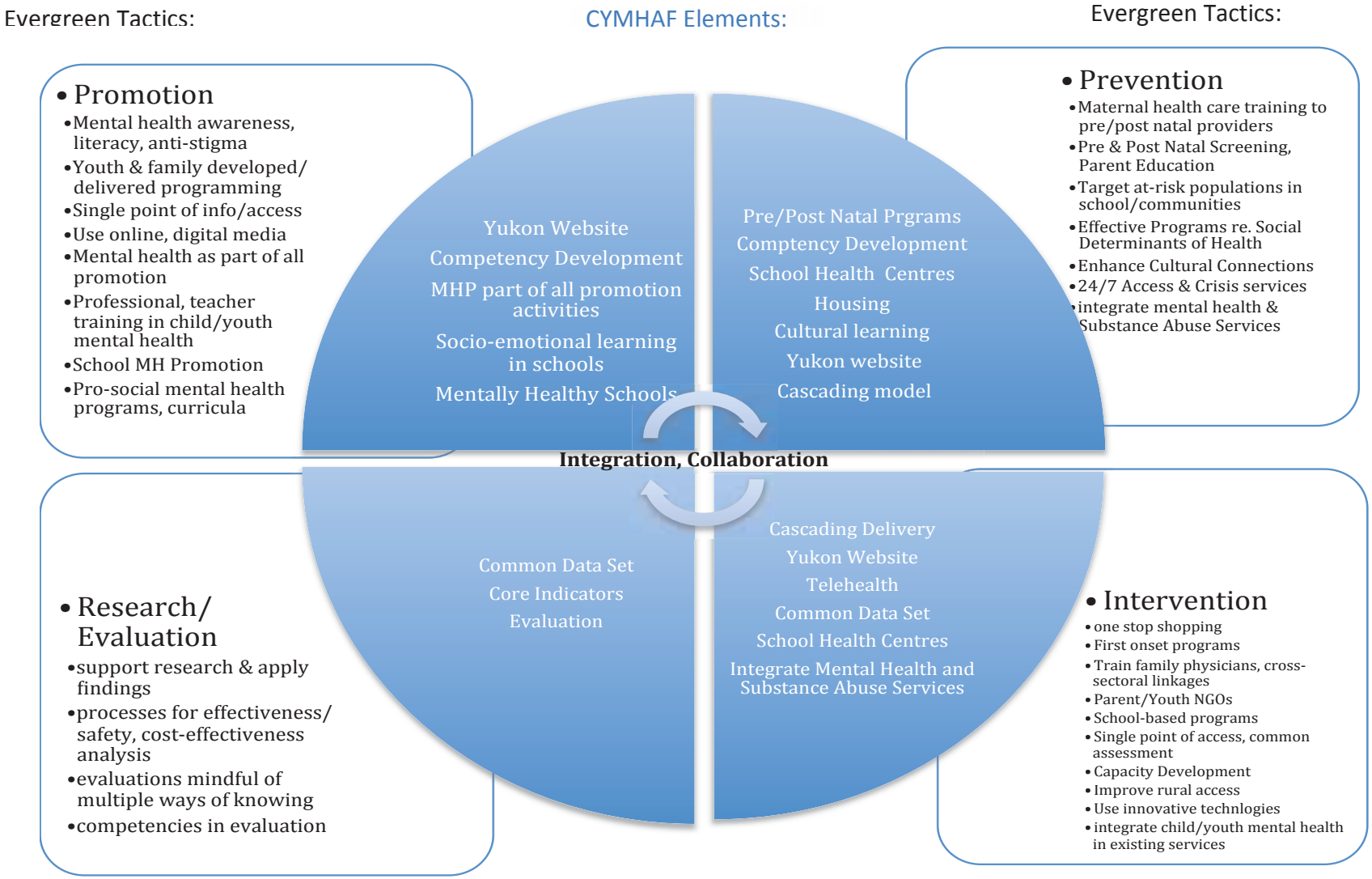
A key message from the development of Evergreen is the importance of having a set of common values as a basis for a child and youth mental health and addictions framework. The Yukon Framework values were proposed by a subgroup of the working group and subsequently endorsed and expanded to include 'Cultural Competency 'by stakeholders at the policy dialogue. Overall many of the identified values were broadly consistent with Evergreen values. Areas of overlap included the emphasis placed on evidence and accountability, timely access to a set of coordinated services, and being child, youth and family centered. There were also two notable differences in values. First, Evergreen is a rights-based framework, whereas the Yukon framework is needs-driven. Second, the Yukon framework places a specific value on capacity development in the area of child and youth mental health and addictions.

Inclusion of Suggested Evergreen Tactics

The Evergreen framework includes a menu of tactics to achieve goals pertaining to each strategic direction. The Yukon framework adopted 13 of 19 Evergreen tactics for the promotion strategic direction; 14 of 19 tactics for prevention; 22 of 29 tactics for intervention and ongoing care; and five of eight tactics for research and evaluation. In Figure 4.0 we group related relevant Evergreen tactics in the background boxes for promotion, prevention, intervention and research and evaluation and we summarize how they were reflected in the Yukon framework in the centre 'pie pieces.'

The circular arrows at the centre of the figure are meant to reflect that a few key elements of the framework (e.g. necessary competencies in child and youth mental health, telehealth capacity in every community, a common electronic health record, and a Yukon website) operationalize multiple tactics that span a number of strategic directions. For example, the Yukon website is used to increase mental health awareness and literacy and reduce stigma (promotion), offer 24/7 information on where to access services in each community (prevention) and make use of innovative technologies (intervention). Similarly, competency development operationalizes tactics of professional and teacher training in child and youth mental health (promotion), improving rural access (intervention) and developing competencies in evaluation (research and evaluation). In this way, the Framework begins the process of integrating activities such as promotion, prevention, treatment and evaluation that are traditionally carried out by separate government areas and agencies.

Figure 4.0 ***Alignment Between Evergreen Tactics and Elements of the Framework***



4.7 Feedback from the Policy Dialogue

Values

Keypad voting was used at the dialogue to assess participant (n=28) support for the proposed framework values that were developed by a subcommittee of the Working Group. Strong support was shown (Figure 4.2). Dialogue participants also suggested cultural Competency be included as an additional value and that additional work be undertaken to determine how to best incorporate it in the framework.

Common Language

Overall, there was a positive response to the terms and definitions provided. However, several participants at the policy dialogue expressed concern that the terms "mental health problem", and "mental disorder" carry negative connotations that contribute to stigma. The recommendation was to continue to use these terms in order to tackle stigma head on, rather than to try to use other terms such as "brain health" or "mental wellness" which could themselves become stigmatized over time.

Needs

Participants appreciated the overview of mental health needs presented at the dialogue. Participants also discussed additional housing needs: (i) supportive housing for youth with severe and complex mental disorders and substance abuse; (ii) crisis, short term and stable housing for the many at-risk youth who do not have a stable housing situation; and (iii) stable housing options for young people more generally.

Service Delivery Model

Participants were generally positive about the cascading service delivery model and had questions about each community's access to specialized programming and expertise in Whitehorse and beyond. It was emphasized that care providers in smaller communities should follow the pathways for access to consultation outlined in the cascading model of health services, care and expertise. The more these pathways are used, the stronger they become, thus building greater competency in individual service providers and communities across the Yukon. It was advised that care providers in small communities should not go around community hubs for consultations, nor should community hubs bypass Whitehorse and consult with out-of-Territory specialists.

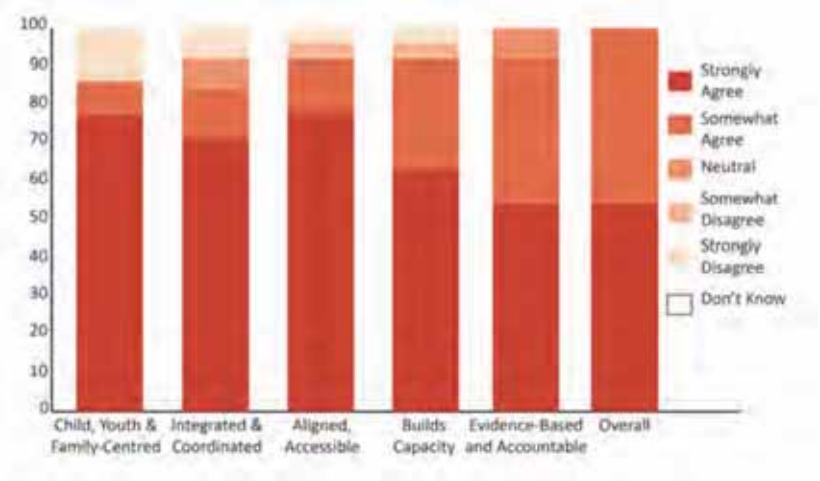
Feedback on additional programming options

Enhanced Promotion and Prevention

Enhanced promotion and prevention options included options for enhanced mental health promotion and prevention in schools; prenatal and parenting programming; on the land First Nations programming; as well as family supports. Among these options, participants prioritized mental health promotion and prevention programming for Yukon children and families from infancy through the high school years. A particular emphasis was placed on programs for parents of children 0-5 years of age as a way to promote mental health and well-being of infant and pre-school children, particularly in many First Nations communities. Participants also prioritized additional school-based mental health promotion and prevention programming for middle school and secondary school students beyond current programs (e.g. MINDUP) and pilot projects underway (e.g. Self-Regulation pilot study). The implementation and delivery of these mental health promotion programs must be flexible and responsive to education service delivery structures and resources of the communities across the Yukon. For example, in many communities schools span the middle

and secondary years. There was also support for family organizations taking a role in advancing mental health literacy, promoting mental wellness, and advocating for children, youth and families throughout the Yukon. Rather than creating a new NGO, it was recommended that the mandate and existing family NGO be expanded.

Figure 4.1 Support for Proposed Values among Dialogue Participants



Enhanced Treatment Options

A number of community and hospital based acute treatment and crisis intervention strategies, supportive housing options and enhanced telemental health consultations were presented for discussion at the dialogue as enhanced treatment options to be considered at a later date. Housing needs were also recognized by participants: (i) supportive housing for youth with severe and complex mental disorders and substance abuse; (ii) crisis, short term and stable housing for the many at-risk youth who do not have stable housing situations; and (iii) stable housing options for young people more generally.

Enhanced Research and Evaluation

Participants were in agreement about the importance of establishing a consistent approach to assessing program effectiveness, and setting standards of care across all mental health care services. Emphasis was placed on the importance of selecting a small number of mental health care (clinical and system) indicators and the creation of an annual scorecard on how well those indicators have been achieved. It was understood that the choice of indicators will require further discussion and should include both clinical and systems level indicators. Suicide rates should not be chosen as an indicator of mental health care as they reflect complex factors beyond the provision of mental health care in the Yukon.

Key Messages: Policy Dialogue

- Participants were supportive of core values, common language, mental health needs, clinical framework
- The cascading delivery model received a great deal of interest among participants
- Enhanced options for promotion, prevention, treatment and aftercare, research and evaluation were viewed as unlikely to proceed at this time.
- Participants were excited by the prospects for reform and eager for implementation. The necessity to proceed carefully to support implementation was discussed.

5.0 Putting it All Together

Table 5.0 summarizes the key elements of the Yukon Framework and the various data sources from which these suggested elements were derived. As can be seen from the table, the vast majority of Yukon Framework elements were suggested by multiple data and information sources. The analyses of feedback on current programs, comparator jurisdictions and suggestions for Evergreen yielded the most suggestions, and there was considerable overlap across these sources.

Common suggestions were to include core values, and to have an understanding of needs; culturally sensitive programs and services; and, a comprehensive spectrum of programs and services that includes mental health promotion, prevention and early identification. These sources also called for a full range of treatment approaches, including collaborative approaches to service delivery across departments, programs, agencies and private providers. There was also emphasis on providing mental health competency development and training, with support provided to rural community-based providers through tele-health and use of other technologies.

The analysis of salient characteristics was most helpful in understanding the specific needs of Yukon and implementation considerations. Population characteristics and Yukon geography led to the development of the cascading service delivery model (described below) and the need for more culturally sensitive programming. Informants from other jurisdictions also supported these approaches.

Participants in the Delphi process stressed the need to develop a common language and core values, foster greater understanding of needs, and to establish a clinical framework for Yukon. These elements, as well as a common framework for competency development should help to enhance capacity and the development of comprehensive program and service requirements. Together these elements will help to clearly establish the role of each service and agency and set the stage for better information sharing, collaboration and planning.

Participants at the clinicians' workshop stressed the need for more promotion and prevention services, including school-based services and more culturally sensitive services. They were also supportive of having providers reside in communities, and of providing additional training to develop skills to meet the mental health and addictions needs of children and youth.

Policy dialogue participants were generally supportive of the draft framework elements that were presented: common language, core values, understanding of needs and the proposed clinical framework. Participants were positive about the proposed cascading model, but at the same time understood that decisions had to be made about the proposed Clinical Services Plan (Health Intelligence Inc., 2014), in order to support the model's implementation. Dialogue discussion also suggested support for a child, youth and family-centred framework, for strong policy and political leadership, and for working with First Nations communities to gain their input and support during implementation.

Based on all of these inputs, the final framework recommends that culturally-informed, evidence-based *basic* mental health care be offered in every community across the Yukon (See companion report which outlines the full Framework and the Framework highlights in section 5.1 of this report). *Basic* mental health care would include mental health promotion, prevention, supportive counselling and problem-solving, identification of disorders and providing referrals to *advanced* mental health care, and substance use harm reduction strategies. *Advanced* mental health care would be provided through primary care located in regional hubs,

consistent with the Clinical Services Plan and would include assessment and diagnosis, first-line treatment planning, consultation and collaborative care, triage and referral, cognitive behavioural therapy and basic psychopharmacology. Enhanced child and youth mental health services would be offered in Whitehorse. These services would include acute inpatient care, crisis management, advanced psychopharmacological and psycho-therapeutic treatment, wrap around care and case management approaches for complex cases, and non-residential addictions interventions. Full details of the services offered and cascading model are provided in the framework document.

In light of resource constraints and governance considerations, health and human service providers from each community would receive *basic* mental health and addictions competency training. These community-based providers would provide basic mental health care and would be supported by and could refer cases to primary care providers in regional hubs who would receive *advanced* child and youth mental health and addictions competency training. Primary care providers in turn would be supported by and could refer to specialists in Whitehorse who would receive *enhanced* competency training. These various levels of support would be offered via existing telemedicine capabilities with electronic linkages using a common data set and a Yukon-specific educational website. Together these various components would create a cascading model of culturally and locally appropriate service delivery throughout Yukon.

The framework also provides a number of recommendations drawn from the various identified sources in Table 5.0 that support framework implementation. These included the need to be child, youth and family-centred, evidence-driven, and to engage First Nations communities from the beginning. There was support for efforts to foster greater collaboration in planning processes and to have built in evaluation mechanisms.

Table 5.0
Common Themes Across Data Sources:

Yukon Framework Elements	Salient Characteristics	Feedback on Programs	Comparator Jurisdictions	Delphi Consensus	Clinicians' Workshop	Evergreen	Policy Dialogue
Content–Related Themes:							
Common Language		✓	✓	✓			✓
Core values		✓	✓	✓		✓	✓
Understanding Needs	✓	✓	✓	✓		✓	✓
Clinical Framework	✓	✓	✓	✓			✓
Culturally Sensitive Programs and Services	✓	✓	✓		✓	✓	✓
Full Continuum		✓	✓	✓	✓	✓	✓
Shift upstream		✓	✓	✓		✓	✓
Integrate Mental Health and Addictions		✓	✓			✓	
Collaborative Service Delivery		✓	✓			✓	
School-based Programs			✓		✓	✓	
Improved information-sharing across services		✓			✓	✓	
Cascading Model					✓		
• Community based services/providers	✓	✓	✓		✓	✓	✓
• Competency development	✓	✓	✓	✓	✓	✓	
• Telehealth/videoconferencing	✓	✓	✓			✓	
• Common dataset		✓				✓	
• Electronic support via website						✓	
Implementation-Related Themes:							
• Child, youth and family centred		✓	✓			✓	✓
• Strong political support	✓	✓	✓				✓
• Strong leadership		✓	✓				✓
• Engage First Nations Communities	✓	✓	✓			✓	✓
• Evidence-Based		✓	✓			✓	
• Ongoing Evaluation		✓	✓			✓	
• Family NGO			✓			✓	
• Improved collaboration in planning	✓	✓	✓	✓		✓	

Framework At A Glance: Putting the Pieces Together

About the Framework:

This section presents an overview of the framework in its entirety and illustrates how each of the components work together to address the mental health care needs of Yukon children and youth. **Components 1 and 2 are shown as rectangles** and form a foundation built on mutual understanding and shared values. **Components 3, 4, and 5 are illustrated as triangles** which outline population Mental Health Needs (**Component 3**), Comprehensive Programming required for a young person at each level of need (**Component 4**) and Service Delivery Model within the Yukon (**Component 5**).

While these components are represented as distinct they are in fact interconnected. Within each component, the most serious mental health care needs are represented first, regardless of the triangle's orientation or placement within the overall framework.

For example, young people with highest mental health needs make up the smallest proportion of population needs ("Mental Disorders" in **Component 3**) require the most intense and broadest array of programming ("Mental Health Services" in **Component 4**). These specialized services are delivered in Whitehorse and OOT by Mental Health Services (***MHS***) (**Component 5**).

In contrast, all people experience Mental Distress (**Component 3**); they can be assisted through a narrow range of programming (Promotion & Prevention in **Component 4**) that is available in all communities ("Across the Yukon" in **Component 5**).

Navigating This Document:

In the pages that follow, the connection between the individual components and the overall framework is shown by the shaded area of the mini-figure at the top right of selected pages. When reading the document on-line, you can navigate to the component of interest by clicking on the corresponding shape in the 'Framework At a Glance' figure or the mini-figures in the rest of the document.

FIGURE 1: **Framework Overview**

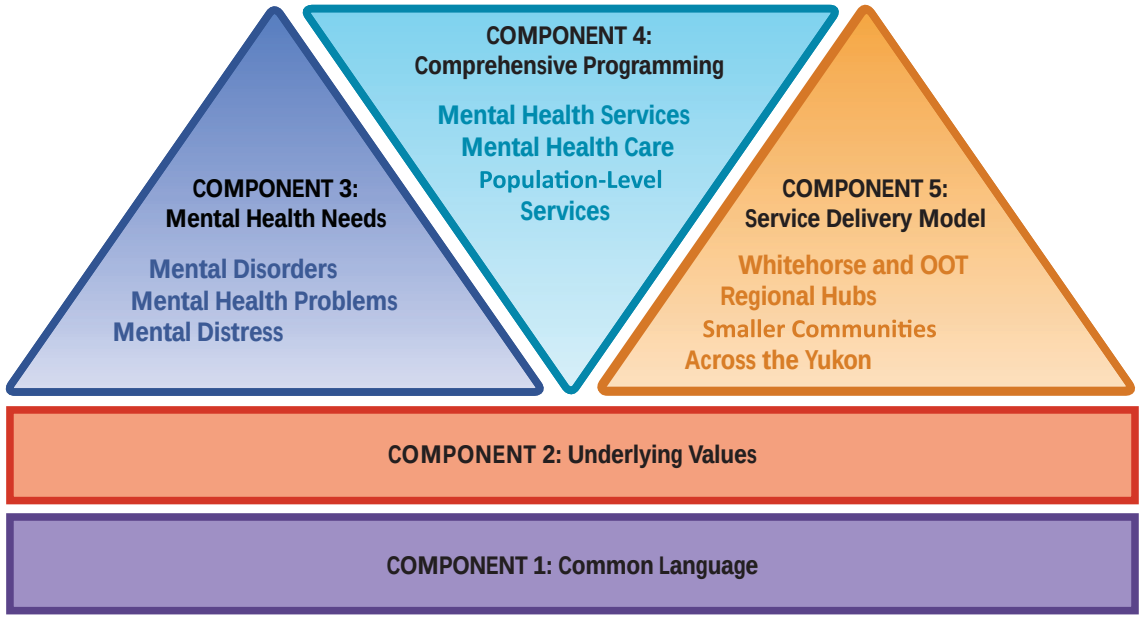


FIGURE 1 A common language and underlying values are the basis for a framework that outlines population mental health needs, services and programming at each level of need and service delivery throughout the Territory. Within each triangle the most serious mental health needs are presented first.

Component 1: Common Language

The framework uses familiar terms in very specific ways. For example, **mental health care** spans the spectrum of promotion, prevention, treatment and ongoing care whereas **mental health services** is a highly specialized component of mental health care. The Government of the Yukon delivers specialized mental health services through Mental Health Services (***MHS).*** Component 1 defines these and other terms in order to build a common understanding across all departments, agencies, and providers that offer mental health care to Yukon children and youth.

Component 2: Underlying Values

The set of five values (child, youth and famly-centred; integrated/coordinated; aligned and accessible; builds capacity; evidence-based and acountable) proposed by a subgroup of the Yukon Working Group received widespread endorsement at the policy dialogue. Cultural competency was an additional value proposed by participants.

Component 3: Mental Health Needs

This component outlines mental health needs across the spectrum for children and youth, and addresses the complex relationship between mental health and addictions needs.

- Of all those who are receiving mental health care, ¼ have a diagnosable mental disorder and of those ¼ have a severe or complex presentation The remainder have a mild to moderate presentation. Mental Disorders are shown at the top of the triangle.
- The remaining ¾ of young people who are receiving mental health care have mental health problems that arise due to life circumstances (e.g. grief, problems in school) that are serious enough to require care such as counseling.
- The bottom of the triangle represents mental distress which is expressed by all children and young people in response to everyday challenges (e.g. losing homework, fight with a friend).

Component 4: Comprehensive Programs

- People with severe and complex mental disorders require the most comprehensive programming, such as assessment, treatment and wrap around services.
- Children and youth with mild to moderate mental disorders require a narrower range of services focused on treating or managing the disorder.
- Children and youth with mental health problems (e.g. grieving loss of a loved one) require access to support and counselling.
- Programs to prevent some mental health problems and mental disorders include a range of universal and targeted programs (e.g. mental health literacy, home visiting programs for young moms)
- Programs to promote mental well-being provide children and young people with opportunities to develop competencies, confidence and connection. These lie outside the health and social services and are typically associated with sorts, recreation, the arts etc.

Component 5: Service Delivery Model

A cascading model puts mental health care, and the identification and referral of youth/families with mental disorders into each Yukon community, with telehealth support from regional hubs and specialized services in Whitehorse and beyond.

- The cascading model puts access to mental health care into each Yukon community and is consistent with Yukon's Clinical Services Plan.
- All health and social service providers will be able to identify children and youth with serious and complex mental disorders, and refer them to specialized mental health services.
- Health and social service providers with advanced training can provide assessment and treatment for mild to moderate mental disorders, and counselling support to youth with mental health problems.
- These services may be provided by local health and social services providers, itinerant providers located in regional hubs, or through telehealth.
- Consultative support to health and socials services providers is available through regional hubs, Whitehorse or out of territory experts.
- Promotion and prevention programs will be delivered by health and human service workers with basic training in all communities.
- The cascading model depends on four core elements: system-wide mental health competency training; telehealth linkages between small communities, regional hubs and specialty services; a common data set; and a website that offers facilitated mental health information and support.

5.2 Financial Considerations

A key issue for Yukon policy makers to consider is what are the financial implications of implementing the framework. While the framework is consistent with a Clinical Services Plan for Yukon (Health Intelligence, 2014) that will establish regional health hubs, and existing telehealth linkages can be utilized, other investments may be required. The major cost is expected to be for child and youth mental health competency development for health and human service workers throughout Yukon. Some additional investments will be required to develop a common data set and a Yukon specific website for facilitated support. An important question is how to obtain funds to invest in capacity development prior to the realization of efficiencies associated with the cascading model.

In order to understand potential areas of cost savings within existing budgets to support framework implementation, we examined financial investments both by the respective ministries, as well as the financial investments required by patients and their families. The intent was to understand where current strategies in the Yukon might differ from other jurisdictions and to determine whether opportunities exist to improve the use of funds, or adjust policies in an effort to reduce or eliminate inefficiencies or inequities in the system.

In addition to what was heard during the focus groups and key informant interviews in the Yukon, the research team examined financial investments by the respective parts of the department that provide services to children and youth, however differences in reporting prohibited a detailed analysis. Based on a review of budget estimates pertaining to child and youth mental health provided by Working Group members[3], it seems that limited funding (typically less that one per-cent) was earmarked for health professional training, which is a key feature of the proposed framework.

This appears to be a departure from the limited information we found in the literature (World Health Organization, 2005). Survey research conducted in the U.S. by Schoenwald et al. (2008) found that of 43 public and 157 private facilities related to "Child mental health services":

"Almost all organizations (92%) provided a formal clinical training program, with 54% of these organizations requiring clinician attendance at such training. Virtually all organizations (98%) allowed staff to attend continuing education unit (CEU) training during work hours, with two-thirds of the organizations providing CEU training, and three-quarters providing reimbursement or paying directly for training provided by others."

In fact, Schoenwald was quite specific on what these training strategies entailed,

"Specifically, clinical implementation support practices, in the form of training and clinical supervision reported by directors bore some resemblance to the training and supervision practices used in EST [Empirically Supported Treatments] effectiveness trials. Weekly supervision was widespread and included observation of treatment sessions (audio, video, or live observation of sessions), and nearly all organizations offered formal clinical training and financially supported CEU training."

It is likely that the small amounts allocated for training in current Yukon budget estimates would not be sufficient to allow staff to attend CEU training on a regular basis as suggested by Schoenwald. The cascading model of service delivery presented in the framework

[3] Representing the Mental Health and EPI program, Residential youth treatment, the Child Development Centre, Counseling in Many Rivers, Child Assessment and Treatment Services, Alcohol and Drug Services Youth Counseling

makes use of available health and human service workers within communities and across Yukon who have received a program of child and youth competency development at the *basic*, *advanced* and *enhanced* levels to offer more immediate access to culturally appropriate and potentially less-stigmatizing care. This model has been used in other jurisdictions facing similar challenges (Kutcher et al., 2005).

Transformative change of this nature can take many years to realize and a staged approach is required (Denis et al., 2011). For example, an application for temporary grants (Territorial or Federal) to invest in training may be a viable strategy, assuming the investments would result in a more efficient use of current services, and these savings could possibly fund, or significantly offset investments in the expanded training strategy in the future. This approach is consistent with that proposed by Armstrong et al. (2012),

"The concept of reinvestment, while not new, is difficult to negotiate, especially during times of fiscal crisis. Yet the lack of such an agreement would result in the temporary use of the grant funds to develop new services, only to have them disappear as the grant funds are reduced over time."

In addition to temporary grants, The research team offers the following observations and potential strategies to free up resources from the existing system to support implementation of the Framework. Some examples follow:

- Potential stigma reduction and improved referral pathways may avoid costly delays in accessing services which result in worsening health status and higher costs within the health care system and potentially within the justice system (Kutcher & McDougall, 2009).
- Offering care in communities may avoid costs of counselors travelling to communities, and, in some cases, reductions in costs of children, youth and families travelling from communities to Whitehorse from distant communities for treatment.
- Offering enhanced child and youth mental health and addictions competency development to resident adult psychiatrists and psychologists in the territory offers the potential to expand the capacity to provide specialist services within Yukon and reduce the number of children and youth who must seek treatment outside the Territory. This may also reduce associated costs.

A broad spectrum of competency development also offers the potential for common understanding of child and youth mental health and addictions needs. This common understanding should facilitate improved collaboration within Health and Social Services, NGO agencies, First Nations communities, educators and other professionals involved in delivering programs and services to children and youth. This in turn may lead to cost reductions arising from less duplication of services. Additional efficiencies may also be gained through the adoption of collaborative models of delivery, which have the potential to reduce costs, although the evidence regarding this strategy is limited (Nelson et al., 2014). The common competency development inherent in the cascading model of service delivery also offers the opportunity to realign resources across Health and Social Services and the many NGO agencies that offer Child and youth mental health services. This can support the development of a common accountability framework and consistent standards and requirements for evaluation of services that may result in further efficiencies. Although the evidence on economic evaluations of child and adolescent mental health interventions is limited (Romeo et al., 2005), potential cost savings may also accrue from the increased focus on mental health promotion and prevention (Freidli & Parsonage, 2007), and the use of telemental health (Hailey et al., 2002).

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