Mindful Paths Forward: Effective Treatment for Youth Experiencing Depression in British Columbia

by

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Project Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Public Policy

in the
School of Public Policy
Faculty of Arts and Social Sciences

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SIMON FRASER UNIVERSITY
Spring 2022

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Abstract

Youth between the ages of 15 and 24 face the highest rates of depression in Canada. Depression is a mood disorder that affects how a person thinks, acts, and feels, and it contributes to a variety of adverse outcomes for individuals and society if left untreated. Despite this, youth in British Columbia continue to face barriers that hinder both help-seeking and the ability to access effective treatments. This study utilizes a literature review, jurisdictional scan, and findings from 15 expert interviews to determine the most significant barriers experienced by youth in BC. Four policy options for increasing access to and use of effective depression treatments among youth in BC are then proposed and analyzed. Ultimately, this study recommends care passports and the implementation of CBT in schools, followed by a survey and coverage of psychotherapy through BC's Medical Services Plan, based on the analysis.

Keywords: major depressive disorder; depression; mental illness; access to depression treatments; youth and young adults; British Columbia

To my parents and everyone else who deserves access to effective treatments for depression.

Acknowledgements

First of all, I'd like to thank my counsellor who gave me the tools to get through these last two years, spent completing a Master's degree in a global pandemic. Being able to access and afford a counsellor that supports effective growth and well-being is an opportunity that so many in BC (and the world) do not have, as evidenced by my research, and I feel tremendously grateful and privileged to have received that. I want nothing more than for everyone who seeks mental health support to have the same experience.

To my supervisor, Olena, thank you for your invaluable guidance and unwavering confidence in me. Your insights helped make this report something that I can be proud of, and I truly feel honoured to have had the opportunity to learn both professionally and personally from you. I also want to thank my examiner, Kora, for challenging me to make this paper the best that it could be. Your perspectives and care for my research are so appreciated.

To the entire 2020 MPP cohort, thank you for making this experience so rewarding and enjoyable. I've never met a group of people so resilient and brilliant. I can't wait to improve policy with you. I'd also like to give a special thank you to my classmate, roommate, and friend, Maegan McKay, for being available all hours of the day to empathize with my stress while simultaneously reminding me of my capabilities, and for making me laugh all throughout.

To my family, who have always encouraged and believed in me, thank you for being so understanding and supportive, and enabling me to make whatever I wanted out of this journey. As for my friends outside of the MPP program: thank you for being patient with me when I disappeared for days, weeks, and sometimes months, in order to meet my deadlines. I'll make it up to you.

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List of Acronyms

AMHS	Adult mental health system
APA	American Psychological Association
ATAPS	Access to Allied Psychological Services (of Australia)
BC	British Columbia
BCPA	BC Psychological Association
CBT	Cognitive-behavioural therapy
CCHS	Canada Community Health Survey
CHA	Canada Health Act
CMA	Canadian Medical Association
CMHA	Canadian Mental Health Association
COVID-19	Coronavirus disease of 2019
CPA	Canadian Psychological Association
CYMHS	Child and youth mental health system
DSM-5	Diagnostic and Statistical Manual of Mental Disorders (5th Edition)
GP	General practitioner
IAPT	Improving Access to Psychological Therapies (of the UK)
IPT	Interpersonal therapy
MCS	McCreary Centre Society
MDD	Major Depressive Disorder
MDE	Major Depressive Episode
MDSC	Mood Disorders Society of Canada
MHCC	Mental Health Commission of Canada
MSP	Medical Services Plan (of BC)
NCCMH	National Collaborating Centre for Mental Health (of the UK)
NHS	National Health Service (of the UK)
PDF	Portable document format
PHO	Office of the Provincial Health Officer (of BC)
PHQ-9	Patient Health Questionnaire-9
UK	United Kingdom
WHO	World Health Organization

Glossary

Allied healthcare professionals	“Healthcare professionals other than physicians and nurses” (Government of Canada, n.d.), which, within the context of this paper, are qualified to provide treatment for depression.
Cultural safety	“An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system” and that “results in an environment free of racism and discrimination, where people feel safe when receiving health care” (First Nations Health Authority, 2017, p. 10). It also requires individual healthcare professionals to address “their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care” and for those professionals to engage in ongoing self-reflection, self-awareness, and accountability in providing culturally safe care “as defined by the patient and their communities” (Curtis et al., 2019, p. 14).
External barriers	“Features of a service that can prevent young people from accessing care” (Stubbing & Gibson, 2021, p. 2).
Indicated school-based CBT programs	CBT programs that “target individuals who show mild or early symptoms of depression” (Calear & Christensen, 2010, p.430).
Inpatient care	“This includes services provided for beds designated for inpatients with mental health or addiction needs in general facilities and in psychiatric facilities” (Canadian Institute for Health Information, 2019, p. 16).
Internal barriers	“Factors within the young person that prevent them from seeking help from formal services” (Stubbing & Gibson, 2021, p. 2).
Mental health literacy	“Encompasses the ability to differentiate a mental health condition from general stress, attributions of mental disorders, and knowledge and beliefs about risk factors and available professional help” (Jorm et al., 1997, as referenced in Cheng et al., 2018, p. 65).
Outpatient care	For the purpose of this paper, outpatient care is defined as any mental healthcare service that does not constitute inpatient care.
Pharmaceuticals	Antidepressant medications.
Psychotherapy	Psychotherapeutic approaches and techniques that usually involve a verbal interaction between a trained professional (ie. a psychologist, counsellor, psychiatrist,

	among others) and a person experiencing emotional challenges of varying degrees (Jordan, 2018, p. 27-28).
Selective school-based CBT programs	CBT programs that target individuals “who are at risk of developing a depressive disorder by virtue of particular risk factors” (Calear & Christensen, 2010, p. 430).
Stigma	“A complex social process of labeling, othering, devaluation, and discrimination involving an interconnection of cognitive, emotional, and behavioural components” (Knaak et al., 2017, p. 111).
Transition management model	“The transition management model focuses on transition processes and practices with the goal of successful engagement of a youth with AMHS” (Carver et al., 2015).
Universal school-based CBT programs	CBT programs delivered to all individuals “regardless of [depression] symptom level” (Calear & Christensen, 2010, p. 430).

Executive Summary

In Canada, those between the ages of 15 and 24, defined collectively as “youth” in this study, face the greatest levels of major depressive disorder (MDD), otherwise known as depression. Despite depression being a treatable mood disorder, youth in BC still lack access to and use of effective treatment, and BC leads the country in rates of unmet mental health needs. Calls for action by advocacy groups emphasize the importance of addressing mental illness in Canada and BC, and recent investments by both the federal and BC provincial government demonstrate political will and salience of the issue.

The new investments are welcomed, although, due to the extent of underfunding that has long existed within the mental healthcare system, it is likely that these new initiatives will not be able to go far enough. Thus, the goal of this study is to determine the best path forward for investments beyond the ones made recently, in a way that mitigates key barriers faced by youth and promotes real systemic reform.

Findings from the literature review and 15 expert interviews highlight six key internal and external barriers that youth in BC face to accessing and using effective depression treatments, which are:

- stigma
- information gaps
- supply of providers
- cost of services
- transition between systems
- tailoring of services

A jurisdictional scan was conducted to gain insights into policies used to address similar challenges by other countries. The United Kingdom, Australia, and Ireland provide feasible policy options to improve access to psychotherapy, but each indicate that one policy will not be enough to tackle the issue of underutilization and access to effective treatments for depression.

Four policy options were derived from the research and were analyzed on their effectiveness, stakeholder acceptance, equity, cost, and ease of implementation. Given provincial government jurisdiction over healthcare, policies are aimed at how the BC provincial government can address the policy problem. The policies considered included:

- psychotherapy covered by MSP
- CBT in schools
- care passports
- a survey

Based on the analysis, a policy bundle is recommended to be implemented using a multi-phased approach. In the first phase, care passports and CBT in schools should be used to aid youth in transitioning from child and youth mental healthcare services to adult mental healthcare services and to ensure effective prevention programs can be deployed systematically to youth. The second phase should consist of a survey, conducted both before and after CBT in schools is delivered to youth, to assess the effectiveness of the policies implemented, collect data on the size of the gap in treatment access and use that persists, and to better understand the diversity of positionalities and needs of youth in BC who experience depression, which is essential for effective policy. Coverage of psychotherapy by BC's Medical Services Plan should also be established for youth, to create a coordinated system of treatment provision without the significant barrier of cost and in a way that reduces the burden on public providers.

Ultimately, the policies recommended within this study work together to prevent the onset of depression in youth and increase the accessibility and acceptability of depression treatments for those in which prevention measures are not enough, thereby benefiting youth and the future of British Columbia.

Chapter 1.

Introduction

Depression is a mental illness that affects how a person thinks, feels, and acts (American Psychiatric Association [APA], 2020). Adolescent-onset depression is associated with worse outcomes than depression that develops in other life periods (Rohde et al., 2013; Solomon et al., 2000), and as of September of 2021, the World Health Organization (WHO) named depression as one of the leading causes of disability and a major contributor to the global burden of disease worldwide (WHO, n.d.). In British Columba (BC), it was estimated that the cost of mental health problems to the economy totaled roughly $6.6 billion annually by 2010 (CMHA, n.d.a). This value has likely grown along with the burden of the illness that has been exacerbated by the COVID-19 pandemic (Moreno et al., 2020; Stanton & Little, 2022), which, together with BC's ongoing overdose crisis (Chan, 2022), indicates an overall crisis in mental healthcare for youth in BC.

Evidence shows that roughly 80% of people with depression will feel better or no longer have symptoms after accessing the right treatment (CMHA, n.d.b). Yet, in 2018, 50% of Canadians reported having some level of unmet mental healthcare needs (Statistics Canada, 2018b). BC has the highest proportion of unmet needs in the country, at 51.1% overall (Statistics Canada, 2018b), and the COVID-19 pandemic has only made things worse (CBC News, 2021; Culbert, 2021; Moreno et al., 2020). Given that youth between the ages of 15 and 24 have the highest depression prevalence rates in Canada (Findlay, 2017), and likely BC (Knoll & MacLennon, 2017), the policy problem being addressed by this study is that **youth face too many barriers to accessing and using depression treatments in BC.**

There are many well-known barriers to accessing and using effective treatment among youth of this transitional age, however not many studies have been able to assess the impact of these barriers for youth in BC specifically. As such, expert interviews of depression treatment providers in BC, conducted as part of this study, serve to ground the barriers within the policy problem in BC. These findings, in addition

to information gathered through a jurisdictional scan, inform the proposal of four policy options that are assessed using five key criteria.

As far as is known at the time of this report, there has been only one study that conducted a comprehensive assessment of access to child and youth mental health services in BC more generally (Cox, 2017). This study is the first to identify the key gaps in BC's mental healthcare system, for youth with depression, in order to develop feasible policy options that address them. Recently, major investments into mental healthcare have been made in BC (Government of BC, 2021b), making this an optimal time to evaluate policy solutions that can inform this work.

The policy recommendations presented here are intended to compliment and expand on current initiatives by the BC provincial government, particularly the "A Pathway to Hope" roadmap (Government of BC, 2019a), which outlines current mental health reform priorities. Additionally, it addresses calls from the Mental Health Commission of Canada (MHCC) more broadly to "bridge the gap between what we know and what we do" in mental healthcare policy, from 2021 (p. 14). Providing effective treatment that is accessible and acceptable to youth is economically beneficial to society. Through reduced risk of suicide, decreased rates of other chronic co-occurring illnesses, better educational and work outcomes, and stronger social relationships, it also leads to better life outcomes and, ultimately, an overall greater quality of life for youth in BC.

Chapter 2.

Background

2.1. Understanding Depression

Major depressive disorder (MDD)[1] is a mental illness classified as a mood disorder (Centre for Addictions and Mental Health, n.d.; Mood Disorders Society of Canada [MDSC], 2019). It affects how a person feels, thinks, and acts (APA, 2020). While there is no single cause of depression, there are many potential risk factors that have been identified by researchers. The Mood Disorders Society of Canada (2019) and the Centre for Addictions and Mental Health (n.d.) list a genetic or family history; biological factors; thoughts and behaviours; recent stressful events; and history of abuse, trauma, or adversities, as potential factors that could lead to the development of depression. Additionally, social determinants such as food insecurity, inadequate housing, unemployment, low income, racism, and poor access to healthcare all increase the likelihood of developing mental disorders (Mental Health Commission of Canada [MHCC], 2017).

In BC, diagnosis of MDD is made through clinical interviews guided by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (5th Edition)*, also known as the DSM-5 (Government of BC, 2013). The DSM-5 outlines the criteria for diagnosis of a major depressive episode (MDE), which is discussed in further detail in the Appendix, and the Patient Health Questionnaire-9 (PHQ-9)[2] is used to identify the number and type of symptoms (Government of BC, 2013). The symptoms presented on the form inform whether the patient meets the criteria for MDD and, if so, the severity of the case, ranging from mild to moderate to severe (Government of BC, 2013).

[1] It is important to note that depression can come in many other forms, such as seasonal affective disorder (SAD), postpartum depression (PPD), dysthymia (or persistent depressive disorder), premenstrual dysphoric disorder (PMDD), and others (APA, 2013). This paper, however, focuses on major depressive disorder and thus "depression" will refer to MDD specifically henceforth.

[2] See here for the full questionnaire: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/depression_patient_health_questionnaire.pdf

2.1.1. Youth and Depression

Among all age groups in Canada, rates of major depressive episodes (MDE) are greatest in the 15 to 24 age range, which is how youth was defined for the purpose of this study.[3] The 2012 Canada Community Health Survey (CCHS), which is the most recent year for which this data was available, found that about 7% of those aged 15 to 24 had a MDE within the previous 12 months (Findlay, 2017).[4] While there is currently a lack of reliable population-based data on depression or other mental illnesses among youth within BC (Office of the Provincial Health Officer [PHO], 2015), tests for heterogeneity across provinces, using a likelihood ratio test for province of residence of CCHS respondents, found no evidence that the national results differed substantially across provinces (Knoll & MacLennon, 2017).

In the literature, youth are highlighted as being especially vulnerable to developing depression for a variety of reasons, including biological maturation processes that affect mood and emotions, and underdeveloped abilities to understand and regulate them (Andersen, 2016; Beames et al., 2021), which overlap with increased stressors and responsibilities that are meant to prepare them for adulthood (Piechaczek et al., 2020; Young et al., 2019). With that in mind, since symptoms of depression in adolescence can look different than that in adulthood (APA, 2013), it is also thought that diagnosis in this population is underrepresented (Mullen, 2018; Thapar et al., 2012). Further, the presence of depressive symptoms even without diagnosis have been associated with increased risks of hospitalization related to mood disorders later in life (Bohman et al., 2018). Thus, it is not just diagnosed cases of depression that should be considered when seeking to mitigate the burden of depression on youth and society, which are discussed in Section 2.1.2, but also symptoms that do not meet the diagnostic criteria.

When assessing depression rates, we must also consider that youth are not a homogeneous group. Youth each have their own unique experiences and positionalities

[3] This is in line with Canadian federal departments definition of youth, which extends into the mid-twenties (Doucette, 2010), as well as the United Nations definition of youth (United Nations, 2013).

[4] For reference, 5% of those between the ages of 25 and 64 and 2% of those 65 years and older reported experiencing a MDE in the same time period (Findlay, 2017).

based on, but not limited to, sex, gender, sexual orientation, immigration status, socioeconomic status, geographic location, ability, language, race, ethnicity, and identities including Indigenous peoples and visible minorities, which often intersect and can affect their risk of depression in a variety of ways. The intersections of these factors have been discussed as essential in informing health policies on global and national levels (Kapilashrami & Hankivsky, 2018). In BC, insufficient data on these intersections presents a barrier to determining groups that are disproportionately at risk of depression (PHO, 2015). There is data to support that new immigrant, refugee, Indigenous, gay, lesbian, bisexual, and transgender youth may be at greater risk for mental illness more generally (CMHA, n.d.c), although these groups themselves are not homogenous and thus there are still gaps in determining the diversity of needs within BC's youth population.

2.1.2. Effects

Depression has been linked to a variety of adverse outcomes, including a general negative effect on quality of life (Tan et al., 2019), and these outcomes have been associated with worse outcomes when onset is during adolescence and recurrent (Wilson et al., 2015). Among youth, depressive symptoms can result in a decline in educational outcomes (Carlson, 2000; Davies et al., 2018); is associated with impaired social relationships, including their acceptance by peers (Davies et al., 2018; Platt et al., 2013); and leads to low self-esteem (Carlson, 2000). Among those in the workforce, depression has been associated with lower productivity in the workplace (presenteeism) and more missed days of work (absenteeism), as well as greater unemployment (Fergusson et al., 2007; RiskAnalytica, 2011). The onset of depression during adolescence means that impaired productivity occurs during prime working years (MHCC, 2012), costing both employers and the overall economy (Birnbaum et al., 2010; Wang et al., 2006).

Reduced life expectancies are also found among those with moderate to severe depression; a difference that can be as significant as 10 to 25 years (CMHA, 2018). The most prominent cause of reduced life expectancy is the risk of suicide, which is especially acute among adolescence (APA, 2013; MDSC, 2019), and is the second leading cause of death among those aged 15 to 24 in Canada (Statistics Canada,

2022a), and among 15- to 18-year-olds in BC[5] (PHO, 2015). Secondly, youth with depression may be more likely to abuse substances (Cheung et al., 2009; Davies et al., 2018), which contribute to a variety of health concerns. Depression is also associated with increased rates of co-occurring chronic medical conditions (CMHA, 2018; Moussavi et al., 2007), including among youth between the ages of 15 and 24 (Cheung et al., 2009; RiskAnalytica, 2011), and was found to have the largest adverse effect on mean health scores when compared to other chronic diseases (Moussavi et al., 2007). Depression therefore also creates extremely high costs to the healthcare system both directly and indirectly (MHCC, 2017; RiskAnalytica, 2011). In 2010, the cost of mental health problems to the BC economy was estimated to be roughly $6.6 billion annually (CMHA, n.d.a).

2.1.3. Treatments

Depression is widely recognized as a treatable mental illness (CMHA, n.d.b; MDSC, 2019; WHO, n.d.). There are two main treatment options for depression: psychotherapy and pharmaceuticals. Cognitive-behavioural therapy (CBT) and interpersonal therapy (IPT) are the two forms of psychotherapy that are backed by the largest volume of evidence for their efficacy in children and youth up to age 17 (APA, 2019; Waddell et al., 2014) and in those 18 and over (APA, 2019). As for pharmaceutical treatments, there are a variety of antidepressants that have been found to be effective in treating depression in those over the age of 18 (APA, 2019; Jordan, 2018). Among those aged 17 and under, fluoxetine, which is an antidepressant of the selective serotonin reuptake inhibitor variety, is backed by the strongest evidence of efficacy (APA, 2019; Mullen, 2018; Waddell et al., 2014). While there are a number of variables to consider when determining the best treatment route for youth with depression, which are beyond the scope of this paper, the most important to understand for this study is that:

- Treatment for youth with depression can be accessed through both in-patient and out-patient care (Canadian Institute for Health Information [CIHI], 2019) – the scope of this paper focuses on out-patient care;
- Early intervention has been declared the “key to treatment of depressed youths” (Mullen, 2018, p. 275), as it can prevent symptoms from increasing in

[5] There was no data available for those over the age of 18 in BC.

severity (Mullen, 2018), increases the likelihood of treatment response, and improves remission rates (Ghio et al., 2014);

- CBT must be delivered in multiple sessions according to severity (Gautam et al., 2020), has been found to have an enduring effect post-treatment, whereas antidepressant treatments have not, and it is also effective at preventing the development of depression (APA, 2019; Waddell et al., 2014); and
- Effective treatment for MDD must be dynamic and long-term, given that it is a highly recurrent illness among this age group (Rohde et al., 2013; Solomon et al., 2000), and recurrent courses of MDD are particularly detrimental (Wilson et al., 2015).

Figure 1 illustrates the potential course MDD can take, including potential timeframes for relapse and recurrence (Gartlehner et al., 2015). Access to effective treatment is required at both the acute stage *and* any relapse or recurrence events to effectively address depression among youth.

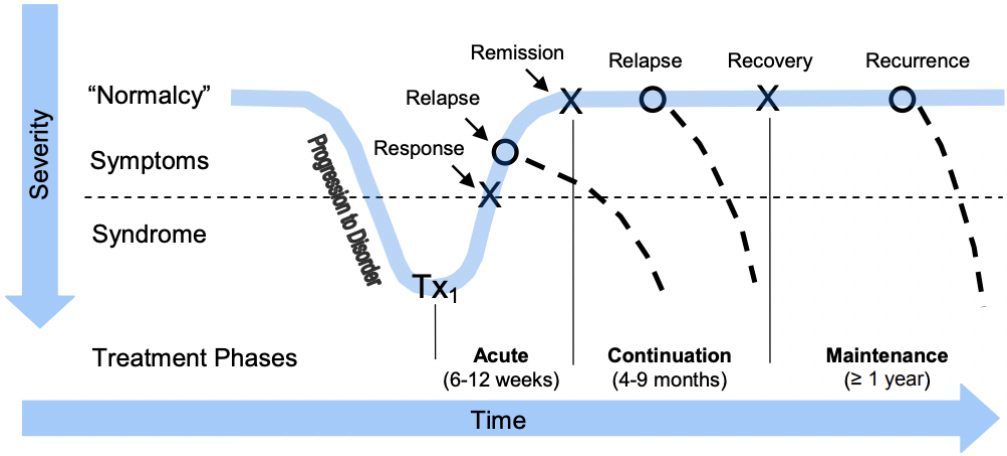

Figure 1. Phases of Treatment for MDD

Access to these effective treatments is severely lacking, which forms the basis of this study. In 2018, 50% of Canadians reported having either partially (15.9%) or fully (34.1%) unmet counselling needs, compared to 14.6% who reported partially (5.5%) or (9.1%) fully unmet medication needs for their mental health (Statistics Canada, 2018b). BC has the highest proportion of unmet need in the country, at 51.1% overall (Statistics Canada, 2018b).

Again, a lack of comprehensive and disaggregated data on treatment usage rates in BC creates a barrier to accurately assessing treatment use and access across this age group. However, a 2018 survey of BC students in grades 7 to 12 provides a

partial estimate, finding that among youth with depression who accessed healthcare services, only 37% of students saw a counsellor or psychologist, while primary care settings were more common: 40% accessed a walk-in-clinic and 23% accessed the emergency room (McCreary Centre Society [MCS], 2018).[6] Data obtained from the Canadian Institute for Health Information (CIHI) found that, in the same year, nearly 65,000 youth (over 10% of that age group) between the ages of 15 and 24 filled antidepressant prescriptions in BC – a rate that has increased across all age groups for at least the past five years (CIHI, 2022; Statistics Canada, 2021c).[7] Even when treatment is accessed, though, there have been high levels of minimally adequate treatment found for those with depression in BC, which was greater among those using psychotherapy than pharmaceutical treatments (Puyat et al., 2016).[8]

2.2. Barriers to Effective Treatment

Potential barriers to effective treatment experienced by youth are well-known. The literature identifies both internal and external barriers that may be faced by youth seeking depression treatment internationally and in Canada, with some references to BC more specifically.[9] Both are discussed below.

[6] No data was provided for the nature of each of the visits, thus it is unclear whether these access rates were for depression treatment specifically.

[7] Since this data only accounts for the number of claimants of antidepressant prescriptions, we are unable to determine the actual usage rates. Additionally, antidepressants are not only used for the treatment of depression (Beck et al., 2005), thus this is likely not an accurate measure of access to pharmaceutical treatment among depressed youth.

[8] In this study, minimally adequate treatment occurred when treatment usage was less than four counseling/psychotherapy sessions or antidepressant prescriptions were not filled within 84 days (Puyat et al., 2016).

[9] Internal barriers are defined as “factors within the young person that prevent them from seeking help from formal services” while external barriers are “features of a service that can prevent young people from accessing care” (Stubbing & Gibson, 2021, p. 2).

2.2.1. Internal Barriers

Stigma

Stigma[10] can emerge through intrapersonal (self-stigma), interpersonal (relations with others), or structural (discriminatory or exclusionary policies, laws, and systems) factors (Knaak et al., 2017), and is a significant predictor of help-seeking intentions among youth with depression (Knaak et al., 2017; Nearchou et al., 2018). It leads to concerns about being treated differently or being labelled by peers, during a time when peer relationships are especially important; self-doubt regarding the severity or validity of symptoms; feelings of guilt about desiring help; doubts regarding their "normalcy" and identity; and fear of symptoms being deemed unworthy of help or left unvalidated by peers and treatment providers (Davey et al., 2008; Dixon-Ward & Chan, 2021; Kilford et al., 2016; Mehra et al., 2021; Stubbing & Gibson, 2021; Wisdom et al., 2006). Stigma and discrimination against patients with mental illness has also been found within the Canadian healthcare system, including low prioritization for them within emergency rooms (Brickell & McLean, 2011; Moroz et al., 2020).

Importantly, stigma may be more prevalent among certain cultures (Salami et al., 2019), could cause greater aversions to group therapy (Shechtman et al., 2016), and may be stronger within older youth (Nearchou et al., 2018) as well as in those with more severe cases of depression (Pyne et al., 2004). There is also evidence that stigma is more often directed towards women and those who do not receive treatment, a diagnosis, or whose depression is not what peers deem severe enough to constitute being "real" (Dixon-Ward & Chan, 2021). This is concerning given adolescent girls' increased risk of depression (Findlay, 2017), and the importance of early intervention in depression treatment. Stigma among families and caregivers is also a concern, given that for some youth, parents can influence the type of treatment their children receive or whether their children seek treatment at all (Mehra et al., 2021; Shanley et al., 2008; WHO, 2012).

[10] Stigma has been defined as "a complex social process of labeling, othering, devaluation, and discrimination involving an interconnection of cognitive, emotional, and behavioural components" (Knaak et al., 2017, p. 111).

Information Gaps

Various gaps in information for youth are described in the literature as potentially impacting their willingness to seek help. Some of these gaps can be classified as a lack of mental health literacy[11], which can create barriers to help-seeking in the following ways: impede the recognition of depression, which makes youth less likely to recommend timely intervention nor identify appropriate treatment; lead them to prefer self-management due to a lack of experience with formal treatment; and hinder their ability to find services or make them unsure of where to look (Coles et al, 2016; Mehra et al., 2021; Wright et al., 2007). Not being informed on processes and regulations within the mental healthcare system can also spark concerns about confidentiality, which youth themselves have expressed as extremely important, especially in relation to parents and caregivers, given the personal nature of the emotional challenges associated with depression (Stubbing & Gibson, 2021; WHO, 2012; Wisdom et al., 2006).

Like stigma, information-based gaps on depression and the mental healthcare system itself may impact people of different positionalities in unique ways. Among some immigrants and refugees, for instance, there are fears that working with psychologists for child mental health concerns could lead to their child being removed from their custody, in addition to concerns regarding deportation, loss of employment, or loss of other resources after admitting to having mental health issues such as depression (Salami et al., 2019). This may lead parents to influence their children against seeking treatment or youth themselves making the decision not to.

2.2.2. External Barriers

Supply of Providers

Mental healthcare in BC can be provided by family physicians, pediatricians, psychiatrists, psychologists, nurses, social workers, and other mental healthcare providers. It has been well documented that Canada has a shortage of these providers (Canadian Medical Association [CMA], 2021; MHCC, 2012). BC has a shortage of

[11] Cheng et al. (2018), in referencing Jorm et al., (1997), defines mental health literacy as "[encompassing] the ability to differentiate a mental health condition from general stress, attributions of mental disorders, and knowledge and beliefs about risk factors and available professional help" (p. 65).

primary healthcare providers greater than the national average (Statistics Canada, 2020), which is especially prevalent in rural regions of BC (Kornelsen et al., 2021).

The most associated problem resulting from the shortages of mental healthcare providers are waitlists that exceed clinically reasonable wait times for treatment (Onge & Déry, 2019). A review of the literature shows that waitlists for mental healthcare in BC are common (Barua, 2015; Goldner et al., 2011; MHCC, 2017). Youth themselves have spoken about their desire for shorter wait times, and how they've witnessed the negative impacts of excessive wait times on their peers' mental health (Stubbing & Gibson, 2021). Untimely access to depression treatments can lead to youth developing more severe symptoms including suicidal ideation (Mullen, 2018) and increases their risk of reoccurrence once their symptoms remit (Ghio et al., 2014), which require more resources to treat and leads to worse life outcomes for youth.

Cost of Services

The cost of pharmacological treatment for BC residents of any age are based on income: those who could benefit from antidepressant therapy and demonstrate financial need can have their prescriptions covered through the PharmaCare Plan G form that are submitted by physicians on the patient's behalf (Government of BC, n.d.a). However, psychological services provided outside of the public system must be paid for by individuals either through private insurance coverage or out-of-pocket (Kelty Mental Health Resource Centre, n.d.; Martin et al., 2018), given that these services are not included in Canada's universal healthcare system as defined by the Canada Health Act (CHA) (Bartram, 2017; Canada Health Act, 1985; Martin et al., 2018).

A recent qualitative study in Canada found that 60% of youth were concerned about the cost of psychological services (Mehra et al., 2021). This coincides with evidence that youth of this generation may be more financially dependent on their caregivers, have higher levels of student debts, and rely more on temporary employment than previous generations in Canada (Statistics Canada, 2018a), meaning they likely have lower ability to pay for mental healthcare services. Recommended fees per psychotherapy session in BC are currently set at $225 when provided by psychologists (British Columbia Psychological Association [BCPA], 2021a) and between $135-$150 when provided by clinical counsellors (British Columbia Association of Clinical

Counsellors, n.d.). [12] Thus, costs of effective long-term psychotherapy can quickly become impossible for youth who may be juggling other expenses or who have minimal income to begin with; despite social determinants such as unemployment and low income making these youth particularly vulnerable to developing mental disorders (MHCC, 2017). Post-secondary institutions and some employers may provide insurance coverage; however, these programs frequently impose restrictions on the number of sessions covered per year, which limit the effectiveness of the access (Peachey et al., 2013), and youth are less likely to have employer-based supplemental private insurance (Martin et al., 2018). Indeed, a recent study of access to psychologists' services showed that the two-tiered system in Canada favoured higher income groups (Bartram & Stewart, 2019).

Different groups in Canada will be more adversely impacted by the high cost of services than others. An online survey study of sexual and gender minorities in Canada, for example, found that the two main barriers to accessing mental health services were an inability to pay (62.3%) and insufficient insurance coverage (52.2%) (Ferlatte et al., 2019). This is a concern for immigrant, refugee, and Indigenous populations as well, given higher rates of low-paying or precarious employment (BCStats, 2011; Salami et al., 2019). We must consider how these and other intersections impact youth who are already economically vulnerable when addressing cost as a barrier to care. Ultimately, high costs of services in the private sector contribute to long wait times in the public sector and lead to serious inequities in care that serve to perpetuate cycles of poverty.

Transition Between Systems

The age range of this study is within the jurisdiction of the two mental healthcare systems, within the public system, in BC: the child and youth mental health system (CYMHS) and the adult mental health system (AMHS). Research in various jurisdictions has indicated that some of the most critical weaknesses in mental health systems is the act of transitioning between them, creating barriers for youth aging out of services (Carver et al., 2015; Davidson & Cappelli, 2011).

[12] While BC psychologists and clinical counsellors are not required to charge the recommended fee, the recommendations can serve as a reference point for fees across the province.

In BC, ageing out of public child and youth services usually occurs at age 18, despite claims that “there is little empirical evidence to support age 18, the current legal age of majority, as an accurate marker of adult capacities” (Johnson et al., 2009, p. 2). Similarly, transitions in other area of youth’s lives are simultaneously occurring, which could include leaving secondary school, moving towards career goals, achieving greater individual responsibility, and potentially moving out of their childhood home (Walker-Harding et al., 2017). As a result, healthcare system transitions at this age have been described as occurring “at the worst possible point in time” and that the consequences leave young people and their families “forced to navigate a new and often quite different system before they are ready and when they are least able to do so” (McGorry et al., 2022, p. 63). When systems and services are not coordinated, or hard to navigate, parents and their adolescent children contact multiple agencies in attempts to access care (Shanley et al., 2008), and these challenges have made ageing out of youth-oriented services associated with premature discontinuation of mental health services, particularly when youth are directed to adult or post-secondary institutional resources without help in accessing them, which can halt their progress and recovery (Carver et al., 2015; Mehra et al., 2021).

Tailoring of Services

Services that are not tailored to the specific needs of youth creates another potential barrier, not only for accessing treatment in general, but also treatment that is effective. In terms of access, most youth at least under the age of 18 can be expected to be in school during weekdays, leaving this time unavailable for them to seek mental healthcare related appointments. Transportation barriers have also been noted as a barrier to accessing treatment by youth (Sylwestrzak et al., 2015). As such, services that are provided during these hours or that are not easily accessible by youth, given their transportation requirements, are less likely to be used by youth (Mehra et al., 2021).

Furthermore, there has been the assertion that youth care cannot simply be added onto child or adult services, given differences in their stage of life, and that youth want services that are focused on their unique needs (Stubbing & Gibson, 2021). Youth seek connection and trust with their mental health providers, value choice in their treatment plan, want to be informed by providers on the illness and potential treatments, and have been found to desire flexibility in including their family members (Mehra et al., 2021; Stubbing & Gibson, 2021; Wisdom et al., 2006). Thus, when this is not

experienced by youth who seek help for their depressive symptoms, they may be less accepting of the treatment offered within the system. Utilization rates are greater when mental health services are targeted to youth needs specifically (Mathias, 2002). This is particularly important for psychological services, which are more personal than the prescribing of medication (Stubbing & Gibson, 2021). Further, youth also require culturally sensitive and diverse treatment options (Stubbing & Gibson, 2021), and this must be provided through care that is anti-racist (Cénat, 2020) and culturally safe (Curtis et al., 2019; Josewski, 2012)[13], otherwise treatment may not be effective even if accessed.

2.3. Current Policy Context

In response to widespread calls for action on mental health policies, the federal Budget 2017 included a $5 billion transfer to provinces and territories to improve mental health initiatives over the following 10 years (Government of Canada, 2017). The funding is intended to improve access to mental healthcare services for Canadians under the age of 25 especially, noting that they "cannot currently receive even basic mental health services" (Government of Canada, 2017, para.15). Bartram (2017) notes that this funding is a "historic first step" but still does not bring mental health spending to a proportion equal to its burden on the healthcare system (p.E1360). In 2019, "A Pathway to Hope" was released, by the Government of BC, as a roadmap for transforming BC's mental health service system from "its current crisis-response approach to a system based on wellness promotion, prevention and early intervention" (Government of BC, 2019b, para. 4). The roadmap outlines four main pillars and a series of three-year

[13] Cénat (2020) provides guidelines for anti-racist mental healthcare, which consists of: an awareness of racial issues, an assessment adapted to the real needs of racialized individuals, a humanistic approach to medicine, and a treatment approach that addresses the real needs and issues related to racism experienced by racialized individuals (p. 930). Similarly, the First Nations Health Authority cites Koptie (2009) in defining cultural safety as "an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system" and that "[i]t results in an environment free of racism and discrimination, where people feel safe when receiving health care" (2017, p. 10). Curtis et al. (2019) adds that culturally safe care requires individual healthcare professionals to address "their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care" and that there must be ongoing self-reflection, self-awareness, and accountability in providing culturally safe care "as defined by the patient and their communities" (p. 14).

priority actions, which include improving wellness for youth and young adults. The investments demonstrate political will, salience, and the timeliness of this study.

A progress report for "A Pathway to Hope" was published in September 2021, which includes updates on a variety of new mental health programs aimed at youth and young adults (Government of BC, 2021a).[14] The pathway is a step in the right direction for youth, in that it begins to address the mental health needs of Indigenous peoples in a variety of ways[15], makes progress on increasing access to primary care[16], and offers support to caregivers[17]. Conversely, in-person youth-focused services are only located in a limited number of communities or school districts, which overlap in some cases[18]; free psychotherapy services are provided through a variety of programs, which contributes to the fragmented nature of the mental healthcare system for youth, and some only offer single-sessions[19]; and programs target early childhood development and anxiety prevention in school-aged children and youth[20], leaving critical gaps for youth experiencing depression. Additionally, the COVID-19 pandemic has made it clear that BC is in a mental healthcare crisis (Culbert, 2021), and thus these measures alone are not enough. Recently, the MHCC released their Strategic Plan for 2021-2031, calling for the closure of "the gap between what we know and what we do" in mental healthcare (MHCC, 2021, p. 14), highlighting the need for policies that put evidence into action.

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[14] The programs include Integrated Child and Youth Teams, Step Up/Step Down Services, expanding Foundry Youth Centres, launching the Foundry Virtual and the Foundry BC App, Mental Health in Schools (focused on promoting positive mental health and addressing anxiety), and 24/7 mental health support for post-secondary students (Government of BC, 2021a).

[14] See Team-Based Primary Care (Government of BC, 2021a).

[15] This includes seven First Nations-run treatment centres, 147 Indigenous land-based cultural and health services, First Nations-led primary healthcare, and a 10-year strategy on social determinants of health and wellness, among other initiatives (Government of BC, 2021a).

[16] See Team-Based Primary Care (Government of BC, 2021a).

[17] See Expand Confident Parents: Thriving Kids and Expanding Foundry Youth Centres (Government of BC, 2021a).

[18] See Expanding Foundry Youth Centres and Integrated Child and Youth Teams (Government of BC, 2021a).

[19] See Foundry Virtual and the Foundry BC App, BounceBack, and 24/7 Mental Health Supports (Government of BC, 2021a).

[20] See Promote Early Childhood Social Emotional Development and Mental Health in Schools (Government of BC, 2021a).

Chapter 3.

Methodology

A variety of qualitative research methods were used for this study, as outlined in this chapter. These include a literature review, jurisdictional scan, and semi-structured interviews with experts in the field, all of which were used to inform the policy options and analysis, which seeks to answer the research question: how can the use of and access to effective treatments be increased among those aged 15 to 24 experiencing depression in British Columbia? SFU's Research Ethics Board approval for this study was obtained on November 23, 2021.

3.1. Literature Review

An extensive review of existing literature on depression, depression treatments for youth, barriers to seeking and accessing depression by youth, and related policies was conducted as part of the research for this paper. Sources were found using Google's search engine, Google Scholar, and SFU's online library. Data was sought from Statistics Canada, however limited provincial level data was available. As a result, data was formally requested from the Canadian Institute for Health Information (CIHI) under the Graduate Student Data Access Program, while other statistics were gathered from peer-reviewed studies.

3.2. Jurisdictional Scan

Countries used in the jurisdictional scan were selected based on information gathered in interviews and through the literature. Care was taken in considering political and structural similarities when determining the countries of focus. Information regarding programs in each jurisdiction was gathered through government websites and literature found through Google scholar and SFU's online library.

3.3. Expert Interviews

15 semi-structured interviews were conducted with various subject matter experts in December 2021 and January 2022. Interview participants were selected based on their expertise and experience, particularly within the age group of interest, and special attention was paid to overlapping credentials.[21] In total, the 15 participants held the following titles: three psychiatrists, one general practitioner, one physician specialist, two registered psychologists (in the private sector), one clinical counsellor (in the private sector), two high school counsellors, one social worker, two academics, and two BC provincial government employees. Each of the participants had experience working in BC, apart from one of the academics. Interview findings were transcribed and then coded using NVivo 12.

[21] For example, this could look like a registered psychologist who also publishes research or a clinical counsellor who also works as a school counsellor.

Chapter 4.

Jurisdictional Scan

While no country distinguishes itself as a particular leader in addressing depression in their youth populations, the United Kingdom (UK) and Australia have both been referenced extensively as models for reform within Canada (Bartram, 2019; MHCC, 2018). Like Canada, Australia and the UK are parliamentary representative democracies with redistributive universal healthcare systems that have histories of limited public coverage of allied mental health professionals, where youth experienced high rates of unmet need (MHCC, 2018). Ireland, on the other hand, provides an example of how to respond to a youth mental health crisis. Additionally, Australia and Ireland were mentioned by interviewees as informing current youth mental health reforms in BC.[22] Thus, policy solutions for increasing access to and use of depression treatments among youth in these countries will be relevant to BC.

4.1. United Kingdom

The United Kingdom's mental healthcare system emerged similarly to Canada's, with hospitals and community-based care as the primary sources of mental healthcare by the 20th century (Wright et al., 2008). However, the healthcare system is much more unitary than Canada's, as it's run by the National Health Service (NHS) (Bartram, 2020). Still, the system has been characterized as underfunded and fragmented, with hospital care covered by national insurance plans while regional authorities oversee community-based and preventative care (Wright et al., 2008). The country faces a similar prevalence of depression to Canada (Mind, 2020), where youth aged 16 to 29 face the greatest rates of depression (Office for National Statistics, 2021) and there is significant unmet need for services (YoungMinds, n.d.).

The Improving Access to Psychological Therapies (IAPT) program was created in 2008 "as a systematic way to organise and improve the delivery of, and access to, evidence-based psychological therapies within the NHS [National Health Service]", with

[22] This was mentioned specifically in terms of informing BC's Foundry Centres.

a focus on those experiencing depression and/or anxiety (National Collaborating Centre for Mental Health [NCCMH], 2021, p. 5). The IAPT program is a grants-based program that uses a stepped-care model and offers online, group, and face-to-face therapy for free at the point of delivery (Bartram, 2020; Vasiliadis et al., 2021). It has been recognized as “one of the world’s largest attempts to disseminate CBT to the general public” (Peachey et al., 2013, p. 71), and its implementation was supported by a strong business case: a cost-benefit analysis was used to estimate that the recovery of program costs would be made within two years, as a result of increased productivity and reduced disability benefit payments (Bartram, 2019; MHCC, 2018).

The program first targeted adults and then was expanded to include those under the age of 18 through the addition of the Children and Young People stream of IAPT (NCCMH, 2021). Almost 10,500 therapists were trained under the program to offer psychological treatments and overall access increased by about 35% (roughly 1.5 million individuals), with individuals receiving 6.7 sessions on average (Vasiliadis et al., 2021). Targets of providing care for 15% of those with mild to moderate mental disorders, wait times that are less than 28 days for 80% of individuals, and clinical recovery in 50% of those served have been reached by the program (Bartram, 2020; MHCC, 2018). Despite these successes, inequities in outcomes persist among ethnic minorities and socially disadvantaged communities (Bartram, 2020; Peachey et al., 2013). These outcomes are tracked through pre- and post-measures of symptoms that are collected during each session and then reported monthly (MHCC, 2018).

4.2. Australia

In Australia, the federal government holds jurisdiction over national Medicare, federal funds make up a much larger portion of health spending relative to Canada’s (61%), and the medical system includes a private health system (Bartram, 2020). Australia’s mental healthcare system has received many critiques, including a lack of coordination and performance monitoring, underfunding, and inadequate pathways to care for groups such as Aboriginal peoples (Holloway et al., 2012; Kilian & Williamson, 2018). As in Canada, youth aged 16 to 24 have the highest rate of mental disorders than any other age group, however this was primarily a result of high anxiety disorders and substance use disorders; roughly 6% of this age group has an affective disorder, with MDD the most prevalent (Australian Bureau of Statistics, 2008). Information (28.5%) and

counselling (25.7%) services were the most likely to not be fully met among those who did access services, and use of services in Australia is lowest among the youngest age group (16 to 24) and the oldest age group (75 to 85) (Slade et al., 2009). The context within Australia, then, is reflective of that of Canada's.

The Better Access to Psychiatrists, Psychologists, and General Practitioners through the MBS Imitative (Better Access) and the Access to Allied Psychological Services (ATAPS) programs were created to increase access to psychological services (Bartram, 2019; MHCC, 2018). The Better Access program expands on Australia's universal public insurance system to include psychotherapy covered by allied healthcare professionals including psychologists, social workers, and occupational therapists (Bartram, 2019). Through these programs, general practitioners (GPs) can prescribe psychotherapy provided by allied healthcare professionals to patients (Vasiliadis et al., 2021). The treatment allied healthcare providers still work in private practice but can choose between charging copayments or provideing services free at the point of delivery and billing the service through the national Medicare plan (Bartram, 2019). The introduction of publicly funded psychotherapy was found to naturally lead to an increase in the psychology workforce (MHCC, 2018) and, between 2006 and 2010, treatment rates increased from 37% to 46% of all Australians with mental illnesses (Bartram, 2020). Evidence shows that users of the program successfully experienced declines in severity of depression, anxiety, and stress: from severe or moderate before treatment to mild or normal levels after treatment (Bartram, 2019).

With increased demand and access, however, came increased costs, which were then partially mitigated through the implementation of session caps for users (Bartram, 2019). Additionally, it was found that, for users, the "one-size-fits-all" approach and the existence of co-payments led to inequities for those of socially disadvantaged backgrounds to persist, while concentrations of providers in urban areas contributes to inequities for those in rural areas (Bartram, 2020; MHCC, 2018). To address these challenges, telehealth access was expanded and the ATAPS program was integrated into Primary Health Networks to better address regional needs (Bartram, 2020).

4.3. Ireland

Ireland does not have universal health insurance, nor does it have universal free GP care, and its medical system has been criticized for being underfunded (Burke et al., 2014). The demographics of Ireland vary from Canada, specifically in its large proportion of young people, as 10- to 24-year-olds make up 19% of its population (Malla et al., 2016). Adolescent mental health reform in Ireland emerged partially out of an apparent endemic of youth suicide, with the fourth highest rate of suicides among 15- to 25-year-olds in Europe (Malla et al., 2016). The country experienced lifetime prevalence rates of mental disorders that reached 56% among 19- to 24-year-olds (Malla et al., 2016), with high rates of anxiety (Higgins & O'Sullivan, 2015). This is relevant to BC given the mental health crisis that has been exacerbated by the COVID-19 pandemic.

Ireland employs the FRIENDS program in schools to prevent anxiety in school-aged children and youth (National Council for Special Education [NCSE], n.d.). In Ireland, CBT is universally administered at a group level by school teachers and school-based mental health professionals (National Behaviour Support Service [NBSS], 2013). In total, the program administers ten one-hour lessons of CBT and includes two booster sessions four months later, and includes a parent component (NBSS, 2013). Three age groups are identified by the program (4-7 years, 8-11 years, 12-16 years) which allows for the program to be developmentally tailored.

After one 10-session course, elevated anxiety levels reduced from 18.8% to 10.2% among participants, which continued after booster sessions, and the program was found to be highly successful as reported by both students and parents (NBSS, 2013). Other assessments of Ireland's FRIENDS program echo findings of reduced anxiety levels, including at four, six, and twelve month follow ups; one study found reduced symptoms of anxiety as far as 36 months post-program (Higgins & O'Sullivan, 2015). All students are found to benefit from the program; however, girls were found to benefit more, and younger students displayed faster responses to the program than did older youth (Higgins & O'Sullivan, 2015). Mental health professionals were found to provide more effective treatment than trained teachers (Stallard et al., 2014). Notably, the populations included in the studies, when reported, were predominantly white students and most studies did not address attendance rates of any of the participants. Overall, while the case of Ireland focuses on anxiety, it proves relevant because anxiety

often precedes or co-occurs with depression (Cheung et al., 2009), some studies have found a reduction in depression from the program (Essau et al., 2012), and because it exemplifies how a school-based CBT program can be implemented.

Chapter 5.

Interview Findings

The analysis of findings from the 15 interviews, with subject matter experts, conducted as part of this study are below.[23]

5.1. Thoughts on BC's Mental Healthcare System

At the start of every interview, interviewees were asked what came to mind when they thought of the current provision of mental healthcare services in BC. Some terms used by interviewees included: *"inadequate", "a mess", "fragmented", "siloed", "hard to navigate", "crisis-driven", "good […] when it's working well",* and *"mixed sentiments".* One interviewee expanded on their description as follows:

> I always compare the mental health system to the cancer care system, and the cancer care system is clearly better. There is very close follow up, there is a very clear treatment pathway, there's very clear guidance to people about what the steps are that they need to take to take care of themselves and to get better from cancer, and then there's after care. In the mental health system, we lack a lot of those components - those critical components.

These gaps, as described below, were recognized as being particularly acute for the age group of focus, although interviewees noted that there was progress being made on the issue. One interviewee highlighted the importance of improving the system for the youth who rely on it: *"I think our youth are our future. If we really want our society to be better, it's something our whole community should come together and support"*.

Importantly, interviewees articulated that reducing depression among youth is possible. One interviewee said the following: *"This is a message of hope. If you're depressed, there's great treatment out there. You can get better. You can feel better. It's obviously a hard diagnosis to have, but it's not like having an illness that can't be treated"*.

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[23] Subject matter experts included psychiatrists, a family doctor, registered psychologists, a clinical counsellor, high school counsellors, a social worker, academics, and provincial government employees, who each worked within BC, with the exception of one academic.

One critical area where it was widely agreed upon that BC's mental healthcare system was lacking was prevention and early intervention programs. Prevention was strongly emphasized as the preferred method of reducing levels of depression among youth and beyond and, as interviewees explained, *"we actually know how to prevent the onset of depression".* CBT, for example, was identified as something that could *"probably be beneficial to almost everyone",* whether they were diagnosed with depression or not. Prevention was described as particularly *"ethical"* because *"it leads to much, much better life chances for kids through depression".* Ultimately, it was said that *"if we don't provide prevention programs and we don't provide treatment right away when somebody is depressed, that's ineffective and puts them at greater risk".*

Within BC's mental healthcare system, interviewees emphasized that it was important that treatment options be tailored to equity deserving groups.[24] One interviewee highlighted culture as contributing to barriers faced by youth, when they said: *"I think there are cultural issues at play as well, as soon as we start considering mental health and how different cultures perceive that"*. BC's system was not viewed as adequately accounting for this. Interviewees emphasized that these populations may require services in a variety of languages, for example, and their positionalities likely result in greater exposure to avoidable adversities that can contribute to depression, such as racism, discrimination, and poverty, which will require specialized care and support. It was mentioned, too, that this may involve moving away from *"evidence-based"* based treatment options to culturally sensitive approaches, even if they have not yet been fully evaluated:

> When I think about depression, I think specifically around CBT, right? So, CBT might work well, interpersonal therapy might work really well, […] but I think that there's other things that can be used, such as Indigenous-led treatments or land-based treatments, that could be just as effective, but we don't necessarily have evidence for them.

5.2. Barriers to Treatment

Given that many of the findings in the literature review speak to national understandings of barriers to effective depression treatments among youth, interviews

[24] Equity deserving groups such as Indigenous peoples, immigrants, refugees, and people within the 2SLGBTQIA+ community were highlighted by interviewees.

with experts in BC were used to confirm and add to our understandings in the BC context. The main barriers found through these interviews are discussed below.

5.2.1. Stigma

Some Interviewees felt that stigma was improving in BC. The COVID-19 pandemic, social media, and increased education and awareness were largely attributed to this. Some examples include:

> I think there's a lot more awareness in BC about mental health issues, and so people are talking about it, people are more open, [there's] maybe less stigma than like five years ago.
>
> I actually think youth have less stigma about it than my age group.
>
> I think the pandemic has been really helpful in that everyone has experienced some mental distress and they're talking about mental health problems. Everyone's talking about mental health and recognizing how important it is. I think that's really helping to reduce stigma around getting help, around talking about it. That's definitely a silver-lining of the pandemic.
>
> I think in a lot of ways, social media has created more pathways to getting services because they become a lot more relatable.

Other interviewees felt stigma was still a barrier for youth in BC, particularly in terms of accessing treatment and among certain cultures:

> I think [for] most people, young people included, […] there's a stigma to seeing a mental health professional.
>
> I do think counselling in general isn't really accessed enough. I think there's still a bit of a stigma attached to it. I think it has gotten better.
>
> I [a high school counsellor] see students for a wide range of things, right? But if I go up to a class, and I call out Johnny, Johnny may feel super apprehensive, because 'oh, the counsellor just came to seek me out, do my friends think that I have an issue?'
>
> I have parents who give their kids [antidepressants], being told that they're drug pushers. I [a psychiatrist] have been accused of being a drug dealer myself. Would anyone ever say that to an oncologist? And yet, you're more likely to die from a mental health issue as a teenager in Canada than cancer.
>
> I think stigma is a huge [barrier], especially if we're looking at other cultures.

As mentioned in the literature review, stigma within BC's medical system itself was also discussed by interviewees. In one case, a interviewee explained:

> There's stigma even within healthcare about mental health patients. It's not uncommon in emergency departments to hear 'they're your patients'. It's like no, no, they're *our* patients. […] There's this thing that psychiatry is like one of the lowest on the pecking order; we get paid the lowest.

5.2.2. Information Gaps

Interviewees discussed many ways in which they've seen how informational gaps hinder utilization of depression treatments among youth in BC. First, as mentioned in the literature review, providers explained that when youth did not have prior mental health literacy, they were especially unlikely to recognize symptoms of depression and in some cases struggled to articulate what they were going through. This was described as especially true given that depression often does not have a sudden onset, making it relatively hard to identify. One respondent noted that *"[i]f it were something that was sudden like a broken bone, it would be easily recognizable, but it isn't."* Another explained that they thought *"people still aren't aware of how treatable depression is; depression is usually very treatable"* but that they felt it was *"getting better".*

Lack of mental health literacy among families more broadly was also mentioned, as evidence by the following quote: *"I think another barrier is probably lack of awareness among kids and also their families and communities - the insufficient awareness that depression can affect children and youth and can do so very severely"*. Moreover, in the interviews, providers noted parental influence on whether youth sought treatment at all. This was explained succinctly by one interviewee: *"I'm seeing over and over that if parents aren't on board with medication or parents aren't on board with going to the doctor, then it doesn't happen"*. Ultimately, as summarize by another interviewee, *"it's easier when everyone's on board*".

Even further, interviewees explained how improving understanding and support among parents can be helpful in promoting the effectiveness of treatment, specifically because of the amount of time that parents are assumed to spend with the child relative to the treatment provider. This is captured by the following interview excerpt:

> I only get to see someone, typically, once every two weeks [in private care]. In community-based care, you might be seeing somebody once a week for an hour or so. But parents are there all the time. So, if you can coach the parents on how to facilitate emotion-focused communication with their teen, that can really provide much more support for their mental health needs.

Another information-based barrier stems from the navigability of BC's mental healthcare system and services. Transitioning between mental health systems and providers exacerbates the challenges associated with navigability, which are discussed more in Section 5.2.5. Given the noted fragmentation and siloed nature of the system, interviewees identified that youth found it extremely hard to identify the necessary steps for care, as exemplified by the following quote:

> If I put myself in the shoes of somebody in that age range, or anybody really, it's hard to navigate. If you're struggling with depression, something like that, really there's no idea. Where would you go? I mean, people go to their GP, right? I know that's the first line for most things, but unless your GP really knows where you should go, it's pretty hard to navigate. We do have a public system, but most people don't really know where that is or who to go to. The private system is completely impossible to navigate. There's websites and phone numbers, and you can call people, but I think people don't really know like: Who am I supposed to call? What do I do? How do I get help for these kinds of things? I think people don't really know.

Adding to what was found in the literature, interviewees explained how a lack of information about how to access help is compounded by the fact that the symptoms of depression itself can make it hard for people with depression to both seek treatment and maintain the motivation to continue with treatment once it has been accessed. Two examples are provided:

> For youth, I find that the navigation issue is especially acute, because for a lot of young people, they have an impediment in terms of advocating for themselves. You know, asking a 15-year-old that's severely depressed to advocate for themselves and to find the service themself, I think, is not a very reasonable thing to do.

> The reality is that both psychotherapy and medications take time to produce change. So, you have to be highly motivated to come to a treatment on a regular basis or take medication on a regular basis for several weeks without seeing any positive results and, at the beginning, especially with the medication, suffering side effects. It requires the level of persistence and motivation that even people without depression might not have, and then when we add on the decrease in energy and motivation that depression brings in itself, that makes it even more challenging.

Youth and young adults also have the additional difficulty of a general lack of life experience with similar systems, as evidenced by the quote below:

> I think for adolescents, it can be particularly hard because they're not sure how to navigate systems in the same way that maybe adults know how to do that. Like, do they have to first contact their family doctor? Do they go on the internet and look for people? And then do they call? Then, do they want their parents involved? Again, if the parents are involved, then they have an easier time navigating those systems and figuring out 'Okay, you're struggling with this, I can help you find somebody to support you with that', but if these youth are trying to figure that out on their own, I think that can be particularly challenging.

5.2.3. Supply of Providers

Interviewees spoke to the lack of providers, of all types, within BC's mental healthcare system as a major barrier to accessing effective treatments, which confirms findings in the literature review. [25] As expected, interviewees explained how this leads to long wait times for services and contributes to a variety of adverse outcomes among youth with depression. Some examples of answers include:

> I think there's not enough resources, quite frankly. There's just simply not enough resources to meet the need and so only the most severe cases are able to access the publicly funded and publicly organized services. […] Whereas other people, that ironically have problems that are more amenable to treatment and early intervention, don't get access, because they're either refused or declined because they're not considered severe enough or the wait is so interminable, you know, one or two years, that people give up.

> I work in private practice and I think our waitlist may even be closed right now. Like, we have a three-to-four-month waitlist, which I think is, particularly for children and youth, quite concerning that people who are even going to pay out of pocket need to have to wait three or four months. And with children and adolescents, we know that that's really critical timing. People often seek help when they're in crisis, and then having to wait such a long time to get services is unfortunate.

> The further north and more remote you get, the harder it is to access services and because of the lack of availability, people who have more mild depression often are on waitlist for like, ever. And because of that, their mood could get worse or we tend to be targeting the really severe

[25] More specifically, family doctors, psychiatrists, and psychologists were mentioned as being in short supply and the ratio of school counsellors to students in high schools was expressed as being insufficient to adequately meet the mental health needs of students in BC.

> episodes of depression. But, really, everyone should have access to therapy.

Another provider expressed scepticism that current policies would be able to meet the growing demand for mental health treatment:

> With the ratios of all the policies that are in place, with more people feeling comfortable [reaching out for help], do we have the means to meet all these things within the medical [system] and within the school capacity? I don't think so.

Currently, provider shortages reduce access to treatment provided by those with the greatest amount of specialized training, even for those who manage to get an appointment with them. One psychiatrist expressed the following: *"I think, right now, psychiatrists don't do a lot of treatment of depression, because there's such a shortage of us. I do mostly assessments and then I'm sending it to other people for the treatment.".*

Importantly, the inability to access services right away was thought to be a deterrent to help-seeking by youth altogether, particularly given that depressive symptoms are not always consistent, which adds to our understandings of the adverse effects of provider shortages. This was explained by one interviewee as follows:

> Especially at that age group, if you're struggling, you want [treatment] right when you're struggling. If you have to wait, you'll just kind of be like 'Okay, well, this feeling has passed for now'. Then they never get that support or access, so that when those feelings come back up again, they don't have the coping skills to manage them.

In cases where treatment for depression is still pursued but accessed late, interviewees referenced the well-established risk of increased severity of symptoms, with one provider providing an example based on their experience working in hospitals:

> You see kids at 14 or 15 trying to take their life, and some do: overdoses, and all these things that people are doing, which is a cry for help and it's a failure of us being able to prevent these. I think it starts six years on average before they get there. So, I think looking at that critical incident, and reminding ourselves that it's not at that moment that they decided to take their life, but that negative thinking started a lot earlier than that.

Adding to the findings in the literature review, interviewees also expressed the belief that provider shortages, long waitlists for psychological services, and billing

incentives made it more likely that treatment providers, who are qualified to provide both pharmaceutical and psychological treatments, would utilize only pharmaceutical treatments for depression. One physician explained how clinical culture, time-constraints, and cost comparisons among treatments play a role in treatment provision:

> That's how a lot of us are trained in medical school: to prescribe. Also, pragmatically speaking, if you've ever had a family doctor appointment, it's like 10 minutes, right? Maybe 15 minutes. There's not a lot of time to talk about the stuff I just talked about and so there's a tendency to pull out the prescription pad because that's faster and easier. It's also covered, right? Most drug plans will cover antidepressants. A lot of drug plans, a lot of health insurance, has very limited coverage for mental health treatments like counselling.

Yet, while provider shortages were emphasized more for psychological services, shortages of family doctors, pediatricians, and psychiatrists also inhibits access to pharmaceutical intervention in BC. For example, interviewees described witnessing youth who do not have a family doctor in BC find it particularly difficult to access antidepressants, including obtaining refills on their prescriptions. This is exacerbated by youth concerns regarding confidentiality when sharing family doctors with their parents, which interviewees confirmed was an important factor. Thus, overall, access to all types of treatment options were found to be affected by the shortage of treatment providers, but this was especially acute for psychological services within the public system.

5.2.4. Cost of Services

As found in the literature, interviewees explained that psychological services in the private sector are extremely expensive, and this correlates to the socioeconomic groups that are able to receive care. One psychologist in the private sector stated quite simply that they *"typically only see higher income groups in [their] private practice, because they're the ones who are able to access those services."*

As expected, youth were recognized as being particularly vulnerable to barriers related to cost because they are at an age where they are either financially dependent on their caregivers or they experience generally lower incomes. Examples of interviewees describing the financial barrier of private system psychotherapy include:

> The cost is so prohibitive. A lot of therapists are charging $150 to $250 an hour. How does someone between the ages of 15 and 24 pay for

> that? It's usually their parents. Now, this is at an age where kids are trying to separate from their parents, so it kind of goes against what the average teenager is doing.
>
> In that 18 to 24 range, a typical psychologist session is like $225. I don't think that, you know, the average young adult has that money to invest, unfortunately, in their mental health.

Not only were depression treatments highlighted as particularly unaffordable for youth, so were the services that treatment providers recognized as healthy behaviours that helped prevent and treat depression, which adds to information gathered in the literature review. Physical activity, in particular, was highlighted by one interviewee:

> I think there's potentially less opportunities for adolescents and young adults to engage in good health behaviours, specifically physical activity. We know that health behaviors become more individually motivated in adolescence. There's less organized sports, less access to gyms. So, if you're leaving high school, you're going to have to now pay to engage in recreational sports, in organized sports, or pay to join a gym, which can be quite pricey. There's just a lot of additional barriers in that age range to engaging in healthy behaviors that we know can promote good mental health as well.

5.2.5. Transition Between Systems

Interviewees also discussed the transition between the CYMHS and AMHS as a major barrier for BC youth. Firstly, the CYMHS itself is hard to navigate because, while there are more public services offered, the public provision of care is offered from a variety of different ministries and programs. For example, interviewees collectively recognized that care, for those 18 and under, is offered from Child and Youth Mental Health teams under BC's Ministry of Children and Family Development; BC Children's Hospital; other public services; some high schools; and the private sector. Similarly, after age 18, interviewees explained that youth could rely on the adult public system (which was said to have much less resources than the CYMHS), the private system, or services offered through university or colleges. Health authorities, family doctors, walk-in clinics, and Foundry Centres were also mentioned as potential places that youth of all ages may look to for services.

Given the lack of coordination and generally unclear pathways of care in the system overall, interviewees confirmed that accessing care in BC's mental healthcare system is particularly challenging for those transitioning between the CYMHS and

AMHS, as found in the literature, simply because of how the system is designed. To explain this, interviewees expressed the following:

> Anytime you transition between one provider to another provider, that's disrupting. So, there's some stuff to indicate that people get dropped through the cracks. If you add the additional filter, that maybe they're going from the pediatric system to, let's say, the university healthcare system because they're going to school, there's another place where things can fall to the cracks. Under those conditions, the only person that really can track what's going on is the person themselves and, oftentimes, we are not the best coordinators of our own care.

> I think, for lots of folks who do become involved with child and youth mental health, […] the system does not provide adequate support for people during that transition age.

> So much of what is going to be effective has to do with building a strong relationship with a provider […], and through those trusting relationships, work through whatever the modality of support is delivered. I think that is hard to find, in general, when you are younger and the folks providing it are not your age. It's particularly hard when the system is designed such that you will be transitioned out at a certain point, regardless of how well you're working with someone.

As mentioned in the last quote, transitioning between systems also means having to gain rapport with new treatment providers, including having to retell personal, sometimes traumatic, stories and histories of treatment. This was *"a common refrain"* that one treatment provider heard from youth "quite a bit", that *"they're worried about having to tell their story, again and again"*.

Finally, as found in the literature review, the separation of the CYMHS and the AMHS was described as an arbitrary division, using *"antiquated"* ideas that adulthood starts at age 18. As one interviewee put it: *"We based [the system] on age, not on challenges that [they] are experiencing."*

5.2.6. Tailoring of Services

It was clear that youth were perceived by interviewees to be their own age group, distinct from both children and adults, in terms of development and general stage of life. Two examples of this are:

> Later in the adult years, like 24, 25, 26 years old - that's when we see prefrontal areas of the brain sort of become more mature and ready. So, there's a biological process that might be happening around [the

> ages of 15 to 24] that also might increase the risk for someone to develop depression.
>
> They're not achieving what I would call the milestones of adulthood until later [than 18], as a society.

Interviewees therefore felt that neither the CYMHS nor the AMHS fully met the needs of youth in BC, which is described below and reaffirms findings in the literature review that indicate care must be tailored to this age group specifically.

The CYMHS was thought to be more well-resourced than the AMHS, but that, within it, youth have been *"looked at with a childhood lens, and […] that's done a disservice to them and has not provided the services that they needed".* This system was described as more "*paternalistic",* where service providers *"lean in",* meaning providers reach out to patients and families when patients do not follow through with care. Families are often very involved in care within this system. While these aspects were actually viewed positively, child providers were, as a result, said to have a harder time understanding *"how to deal with adult education or college or university, [or] how to make sure that we allow kids to be more independent if they don't want to have their families involved, and have a sense of autonomy and capacity that would exclude the families"* for those that are in the CYMHS but are transitioning towards adulthood.

On the flip side, the AMHS was described as being *"really geared towards working people, people who have jobs and families, people who have a car".* Interviewees explained that this could mean that *"an adult provider might treat an 18- or 19-year-old the same way that they might treat a 41-year-old, with an expectation of significant autonomy and capacity, when in reality, they might not have that".* This could lead to life circumstances such as school transitions being less understood, or youth suddenly expected to be able to make all their decisions on their own after not having that full autonomy for their whole life up until that point.

Other areas in which the current services were confirmed to affect the applicability of services to youth include hours offered for services; locations that do not account for transportation difficulties for youth who may not have access to a car; and putting 18- to 24-year-olds, who are in adult care, in group therapy sessions with people in vastly different stages of life. Overall, this was described as affecting the effectiveness and acceptability of services by youth.

Chapter 6.

Policy Criteria, Measures, and Options

6.1. Policy Criteria and Measures

A multi-criteria analysis was conducted to evaluate potential policy options that address the policy problem: that of insufficient use of and access to depression treatments among youth in BC. Five criteria and six measures were determined through the above research and are summarized in Table 1, and then presented in detail within this chapter, outlining how the policy options were evaluated.

Table 1. Policy Criteria and Measures Summary

Criteria	Definition	Measure	Coding
Effectiveness	Extent to which the policy improves access to effective depression treatments among youth	Significantly increases access to treatment	Good (3)
		Moderately increases access to treatment	Moderate (2)
		Minimally increases access to treatment	Poor (1)
Stakeholder Acceptance	The level of acceptability of treatment provision among youth experiencing depression	High acceptability of treatment	Good (3)
		Moderate acceptability of treatment	Moderate (2)
		Low acceptability of treatment	Poor (1)
Equity	Degree to which culturally sensitive treatment options can be incorporated	High ability to incorporate culturally sensitive treatments	Good (3)
		Moderate ability to incorporate culturally sensitive treatments	Moderate (2)
		Minimal ability to incorporate culturally sensitive treatments	Poor (1)
	Ease of access among youth in remote and rural communities	Easy access for remote/rural youth	Good (3)
		Moderate access for remote/rural youth	Moderate (2)
		Difficult access for remote/rural youth	Poor (1)

Criteria	Definition	Measure	Coding
Cost	Cost to government in Canadian dollars	Low cost to government	Good (3)
		Medium cost to government	Moderate (2)
		High cost to government	Poor (1)
Ease of Implementation (x0.5)	Complexity of implementation	Low degree of complexity of implementation	Good (3)
		Moderate degree of complexity of implementation	Moderate (2)
		High degree of complexity of implementation	Poor (1)

6.1.1. Effectiveness

The main objective of this research is to reduce the level of major depressive disorder and related symptoms among youth in British Columbia. Thus, one of the criterions used to assess how well policy options achieve that goal is effectiveness. Effectiveness will be measured by the extent to which it increases access to depression treatments among youth. Factors such as increased supply of providers, reduced cost of services, and improved navigability will affect this measure. Efficacy of the treatment that access is improved for will also be considered. Policies that significantly increase access to treatment will earn a **high** rating, while policies that moderately increase access will earn a **moderate** rating, and policies that minimally increase access will earn a **poor** rating.

6.1.2. Stakeholder Acceptance

In order to reduce depression rates among youth, there not only needs to be an increase in access to services, but also acceptance of the modalities of treatment by those who need them. Another objective of the analysis, then, is to assess the level of acceptability of treatment provision among youth experiencing depression. Factors such as reduced risk of stigmatization, easily accessible locations for youth, appropriate service hours, and assurance of confidentiality will all lead to greater acceptability among youth. Policies that are expected to be highly acceptable to youth will earn a

rating of **high**, while policies that are expected to be moderately acceptable will earn a rating of **moderate**, and policies that are expected to have low acceptability will earn a rating of **poor**.

6.1.3. Equity

The analysis identified two main equity issues in the current provision of depression treatment in BC: that of a lack of culturally sensitive treatment options[26] and lower access in rural and remote communities. Thus, the two measures of equity include the degree to which culturally sensitive treatments can be incorporated into the policy's implementation and the ease of access for those within rural/remote communities. Both will be rated as **poor**, **moderate**, or **good**, with policies that have a greater ease of access in rural/remote communities and ability to incorporate culturally sensitive treatments earning better scores.

6.1.4. Cost

The cost of mental health services has always been a crucial factor in policy selection by the provincial government, especially given that outpatient mental health services are not funded through the federal Canada Health Transfer payments (Bartram, 2017). Cost will be measured in Canadian dollars and will consider only upfront and ongoing costs, rather than return on investments, considering we know that the goal of decreasing depression, which is sought by all policies considered, will inherently generate large payoffs.[27] Policies that have a low estimated cost to government will earn

[26] There has been an important distinction made between culturally sensitive and culturally safe health policies. In contrast to the First Nations Health Authority's (2017) definition of cultural safety, mentioned previously, as "an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system" and "results in an environment free of racism and discrimination, where people feel safe when receiving health care" (p. 10), cultural sensitivity "is about realizing the legitimacy of difference" (First Nations Health Authority, 2017, p. 10). It is essential that all policies proposed by this report be done in a culturally safe (and anti-racist) manner, although how that is to be done is beyond the scope of the research. Thus, this criterion focuses on how flexible each proposed policy is in allowing for differences (ie. cultural sensitivity) in positionalities, including needs for Indigenous-led treatment options, provision in various languages, accessibility features, and others, which are also essential and were discussed in the interviews as currently lacking.

[27] See Section 2.1.2 for how depression results in indirect and direct costs to the healthcare system and the BC economy, and see Vasiliadis et al. (2017) for an outline of potential returns on

a rating of **good**, while moderate costs earn a rating of **moderate**, and high costs earn a rating of **poor**.

6.1.5. Ease of Implementation

Ease of implementation evaluates the level of complexity required to implement the proposed policies. Factors such as legislation changes, coordination among multiple ministries, the need for other stakeholders to be involved, and a long implementation period will all increase the complexity. This criterion will be measured by **good, moderate,** or **poor** levels of complexity of implementation, with greater complexity earning lower scores. This criterion is half weighted in the analysis, as the Government of BC has demonstrated willingness to implement complex policies on this issue, through the "A Pathway to Hope", yet it can still be assumed that policies with greater ease of implementation will be favoured over policies that are harder to implement.

6.2. Policy Options

Four policy options were derived from the research and are described below. All four options aim to effectively increase access to and use of depression treatments among youth in BC, so that rates of depression among this age group decline. Given provincial jurisdiction over the healthcare system, the policies are directed towards actions that the Government of BC could take to alleviate the current disparity and take into consideration programs that are already underway in BC.

6.2.1. Psychotherapy Covered by MSP

There have been calls for the coverage of allied health professionals' provision of psychotherapy under BC's Medical Services Plan (MSP) by the British Columbia Psychological Association (BCPA, 2021b), and public polling shows that this is supported by British Columbians (Nanos, 2020). Some interviewees also expressed their support for this policy option.[28] Currently, the Foundry Virtual app offers free online

increasing access to psychotherapy. Cost savings of each policy would be proportional to the decline in depression levels among youth that it achieves.

[28] Interviewees expressed their support for this policy option through comments such as: *"I think the number one way we can improve services and access to services is to make [therapy]*

counselling for BC youth aged 12 to 24 and their caregivers, BounceBack provides free CBT to those aged 15 and up, while other short-term therapy options are also offered, all through the "A Pathway to Hope" initiative (Government of BC, 2021a). These programs offer similar services but do so using different avenues of access and contribute to the uncoordinated and fragmented nature of the system that was discussed by interviewees. Considering how interviewees highlighted navigability of the system as a challenge for youth, this policy proposes a more broad-ranging policy of all psychotherapy covered by MSP, to integrate free psychotherapy provision across the province for youth in BC. It would also serve to enable youth access to any allied healthcare provider for psychotherapy, not just those employed within the public system and the above mentioned public programs.

This policy option is not without precedence in Canada. Provinces and territories have autonomy over what services are considered "medically necessary" beyond the services required by the CHA (Banting & Corbett, 2002; Bartram & Lurie, 2017), which are "funded and delivered on their own terms and conditions" (Government of Canada, 2011). Accordingly, in December 2017, Quebec announced a $35 million investment to introduce the first public psychotherapy program in the province, modelled off of England's IAPT program (Government of Quebec, 2017). Roughly 3% (240,000) of the population was expected to be able to access psychotherapy annually as a result of the investment (Government of Quebec, 2017). The implementation of the program began with a pilot aimed at children and youth with depression in two Quebec regions (Government of Quebec, 2018), highlighting the importance of improving access for this group. Importantly, waitlists of up to a year, in some cases, were still present following implementation (Stevenson, 2021). This has been attributed to provider preferences for working in the private sector, given higher wages and the existence of the parallel system (Stevenson, 2021).

The goal of this policy is to ultimately increase access so that youth with depression can gain the treatment they need to improve their quality of life. This policy allows for flexibility in which allied healthcare professionals' services would be covered[29]

covered by MSP" and *"I think that's one of the important solutions that we have to figure out, is to provide publicly funded psychotherapy".*

[29] For example, psychotherapy covered by all registered psychologists and/or registered nurses, clinical counsellors, etc.

and, given that the policy is insurance-based like that of Australia's program, would not require current providers to transition into the public system. For completed sessions, providers would bill MSP directly for payment, making the service free at point of service. It is recommended that both GP-referral and self-referral be accepted (MHCC, 2018), as well as the provision of both in-person and virtual sessions. Given the inequities that persisted in the UK's IAPT program and Australia's Better Access and ATAPS program, this policy also proposes that there be an appropriate session limit per person annually for this coverage; this ensures that those who have already been able to afford care and thus have contact with a private provider already do not monopolize their services by utilizing unlimited sessions. An exemption program could be put in place between providers and the province for cases which may reasonably require more sessions.

6.2.2. CBT in Schools

BC's mental healthcare system was critiqued by interviewees for its lack of preventative measures and untimely interventions in youth depression, which leads to significantly worse outcomes for youth across their lifetime. Interviewees also emphasized the importance of policies that meet youth where they are at and "lean in" to promote continued use of treatment. Elementary, middle, and secondary schools are likely the only time there is a centralized system that can access most children and youth in BC. The administration of CBT, which has been extensively proven as effective both as a treatment and prevention method for adolescent depression in group and individual settings (APA, 2019), within schools is thereby expected to help provide this service to youth across BC in a systematic way.

There are three types of school-based CBT programs: universal, selective, and indicated (Calear & Christensen, 2010). While there is some evidence that indicated and selective school-based CBT programs[30] are even more effective at reducing and preventing depression symptoms in youth than universal programs (Horowitz & Garber, 2006), there are a variety of trade-offs between the three types of programs (Calear & Christensen, 2010), which are relevant to BC. Specifically, universal programs are associated with less stigma and time, as they do not require screening of students

[30] Indicated programs target individuals who show mild or early symptoms of depression, while selective programs target individuals who experience risk factors associated with the development of a depressive disorder (Calear & Christensen, 2010).

(Calear & Christensen, 2010). Both stigma and time (through a lack of supply of providers) are barriers within BC's mental healthcare system. Moreover, following their systematic review of such programs, Calear and Christensen (2010) argue that the focus "should maybe not be on comparing the effectiveness of indicated and universal programs, as there is evidence to suggest the potential of both, but rather focus on the programs being utilised and what it is about their content and delivery style that make them more or less effective" (p. 435).

Thus, this policy considers the implementation of a universal CBT school-based program for all school aged individuals in BC, designed through collaboration with mental healthcare professionals to support effective content and delivery. This policy was supported by the interviewees[31] and is modeled after the FRIENDS program in Ireland. Further, CBT in schools would expand upon the *Mental Health in Schools Strategy* within BC's "A Pathway to Hope", which currently focuses on providing resources to educators on how to prevent anxiety in school-aged children (Government of BC, 2021a), to include treatment for depression in a course-based format.

The goal of this policy is to provide preventative treatment and early intervention, which both lead to improved outcomes for youth across their lifetime (Ghio et al., 2014). Like in Ireland, the program should include both initial and booster sessions, all of which would be provided during regular school hours (for one hour a week) in group settings each school year, in addition to a parent information component, without any costs to parents or students. Ireland's FRIENDS program used both classroom teachers and school-based mental health professionals to provide CBT in classroom settings, though treatment provided by mental health professionals were found to have better outcomes than treatment provided by teachers who had been trained to provide the services (Stallard et al., 2014), as was found in other school-based CBT programs (Calear & Christensen, 2010; Pössel et al., 2018). Interview findings also support using mental health professionals rather than teachers for mental health programs in schools.[32] Thus,

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[31] For example, one interviewee said *"CBT, if that's something that they could teach in the public school system, […] I think that would be maybe a much more effective way because then everybody learns the skills".*

[32] It was expressed in the interviews that *"teachers sometimes don't feel comfortable addressing [mental health curriculum], because they don't feel like they're experts in that field and they don't want to say the wrong thing to someone or trigger someone the wrong way. So, there's definitely*

this policy is assessed based on the use of school-based mental healthcare providers delivering developmentally appropriate universal CBT sessions in schools.

6.2.3. Care Passports

A significant barrier to effective treatment, specific to youth, is that of the transition from CYMHS to AMHS. This transition has been described as occurring at the "worst possible time" for youth (McGorry et al., 2022, p. 63). Interviewees discussed how the presence of depressive symptoms, on top of this, make it especially hard for youth to maintain motivation to follow through with treatment, which is exacerbated by the disjointed and uncoordinated system. As a result, youth have been found to end treatment prematurely during this transition, unable to gain access to the adult system after aging out or deciding not to reach out again in fear of having to retell their stories to new providers. This policy therefore proposes a system of "care passports" be utilized by healthcare professionals to aid youth in the transition from CYMHS to AMHS, which is based on findings from the interviews and aligns with the MHCC's calls for the use of transition management models to improve this transition (Carver et al., 2015).

Care passports are booklets that are filled out by care providers and carried by youth when they seek new providers, thereby reducing some of the burden they face in facilitating their own successful care. This will reduce the need for youth to have to retell their stories to new healthcare providers. The inclusion of accessible, clear instructions for how to make the transition will also help promote their access to next providers, ensuring they are able to access continued support. Healthcare providers will presumably be able to provide better quality services, as well, by receiving accurate and thorough histories of patient treatments, better preparing them for the continuation of that treatment.

Notably, a system like this has already been established and is in use within BC: the child health passport is provided to BC parents following the birth of a child.[33] The passports currently track health information such as growth rates, hearing, dental, and

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a level of hesitance to cover some of these materials or to go in depth with some of these things [by teachers]."

[33] See here for a PDF of the Child Health Passport: https://www.health.gov.bc.ca/library/publications/year/2016/child-health-passport-eng-2016.pdf

vision checks, immunization records, and provides healthcare information to parents (Government of BC, n.d.b). Mental health "care passports" could replicate or be added to this document.

6.2.4. Survey

There have been calls for reliable and accurate data collection on youth well-being in BC, and for this data to inform policy and service delivery (PHO, 2015). The importance of better and more fine-grained data collection in policymaking was also emphasized within the interviews.[34] A lack of comprehensive and disaggregate data for depression prevalence, treatment use, and access across not only age groups in BC but also a variety of other positionalities, which intersect and result in unique barriers and risk-factors[35], proved to be a significant barrier to this study. It also creates a barrier to effective policies that cater to the diversity of youth and, subsequently, those that are disproportionately affected or who have unique needs (Kirmayer & Jarvis, 2019). Without this detailed data, policies are more likely to be broad-ranging, which will ultimately be less effective for the variety of youth whose needs are not captured.

This policy therefore entails a comprehensive survey to determine prevalence of mental illnesses within the population (disaggregated for each disorder), treatment access rates, help-seeking behaviour, and other factors and personal characteristics, including their intersections. The McCreary Centre Society (MCS) conducts the BC Adolescent Health Survey among youth in grades 7 to 12 every five years (McCreary Centre Society [MCS], n.d.), and collaborates with a variety of BC ministries on it (PHO, 2015). The survey collects data on a variety of adolescent health topics, including mental health. It is not, however, sufficiently detailed in regards to mental health information, nor is it sufficiently disaggregated in personal characteristics and experiences, and so this

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[34] One interviewee, who was a provincial government employee, explained this quite clearly: *"We need to know how well [recent initiatives are] working and for whom. We know from the data from the Foundry Centres, for those who are coming in the door, [that] that seems to be working quite well for the most part, but it's very hard to say for those who are not. […] I think that in terms of policies, it's partly a matter of evidence gathering for the broader population and, particularly those who are not necessarily accessing services yet, [which] is one of the most critical elements of building good policy."*

[35] This includes factors such as geographic location, sex, gender, socioeconomic status, sexual orientation, ability, immigration status, language, race, ethnicity and identities including Indigenous peoples and visible minorities.

policy would consist of the enhancement of the MCS's Adolescent Health Survey to account for these informational gaps. The survey would need to be distributed using a variety of methods, such as by mail and online, and be available in a variety of languages and formats to ensure accessibility for all groups. Although the MCS's Adolescent Health Survey is not distributed to the entire youth population, as defined by this study, enhancing the MCS survey provides an important starting point for addressing the key goal of this policy, which is to capture the diversity of needs among BC's youth population.

Chapter 7.

Analysis of Policy Options

This chapter provides an analysis of the policy options proposed in Chapter 6. Table 2 provides a summary of the analysis: the conducting of a survey earned the highest score of 13.25, followed by both CBT in schools and care passports earning a score of 13, and psychotherapy covered by MSP with a score of 10.5.

Table 2. Summary of Policy Analysis

Objective	Psychotherapy Covered by MSP	CBT in Schools	Care Passports	Survey
Effectiveness	Moderate/Good (2.5)	Good (3)	Poor/Moderate (1.5)	Poor (1)
Stakeholder Acceptance	Moderate (2)	Good (3)	Moderate (2)	Good (3)
Equity	Moderate (2)	Moderate (2)	Good (3)	Good (3)
	Moderate (2)	Good (3)	Moderate (2)	Good (3)
Cost	Poor (1)	Poor (1)	Good (3)	Moderate (2)
Ease of Implementation (x0.5)	Moderate (2)	Moderate (2)	Good (3)	Moderate/Good (2.5)
Total	**10.5**	**13**	**13**	**13.25**

7.1. Psychotherapy Covered by MSP

7.1.1. Effectiveness

The literature review and interview findings established that youth are especially economically vulnerable – they are more likely to depend on their families or on limited income to support themselves financially. Further, a recent qualitative study found that 60% of Canadian youth were concerned about the cost of psychological services (Mehra et al., 2021). Providing free psychological services will increase access to effective

depression treatments for those of which cost is a barrier. The ability to see both public and private allied healthcare providers free at point of service will also eliminate the barrier of navigating through a variety of programs within the mental healthcare system for youth, which is a barrier emphasized through interviews with BC providers. Similarly, by enabling youth to access allied healthcare professionals in the private system for free, this policy also reduces the burden of demand on providers who work in the public sector, which are currently highly demanded due to their free provision.

However, given that supply of providers is a barrier to accessing services in general, even within the private sector, as expressed by interviewees, the policy has some limitations in the capacity to increase access across BC's mental healthcare system as a whole. In other words, there is no inherent increases in the supply of providers within BC from this policy. Evidence from the jurisdictional scan, though, supports that an insurance-based approach is more conducive to increasing provider supply, considering that Australia's Better Access and ATAPS insurance-based programs led to a natural increase of providers (MHCC, 2018), while Quebec experienced difficulties maintaining staff levels in its public sector provision of psychotherapy due to competition in its parallel private system (Stevenson, 2021). Further, limited supply of providers will be mitigated partially through the session limits, although an inappropriate limit will itself hinder effectiveness of this initiative. Ultimately, due to the elimination of fees, increased navigability, session limits, and potential but not guaranteed increase in the supply of providers, this policy earns a **moderate/good** rating for effectiveness.

7.1.2. Stakeholder Acceptance

Interviewees expressed that they saw extremely long waitlists for youth seeking psychological services, especially among the public sector where the provision is free, which exemplifies demand and acceptance of this service by many youth. Additionally, the provision of virtual psychotherapy appointments will be useful to youth given that they may face barriers to accessing transportation, which is supported by findings from Foundry Virtual BC that showed 30% of youth using their services could not access in-person services in their communities (Foundry, 2021). In 2020, a survey of Canadians found that 71% would be willing or somewhat willing to access psychological treatment virtually (Canadian Psychological Association [CPA], 2020). This is supported by the

success of both Foundry Virtual BC and BounceBack, which both provide only online services to youth (Foundry, 2020; Government of BC, 2021a).

Conversely, some youth might still feel stigma towards the use of psychotherapy, or any services at all, and so this policy will likely not be accepted by *all* youth. In a recent study of youth with depression, 87.6% said that they preferred to handle their symptoms on their own, 63.8% feared what others thought of them using psychotherapy, and many feared not being able to establish a relationship with their therapist, which all contributed to lower levels of help-seeking behaviour for psychotherapy (Mehra et al., 2021). Acceptance among youth therefore earns a **moderate** score for this policy.

7.1.3. Equity

It would be possible to offer some forms of culturally sensitive treatment through psychotherapy coverage, such as treatment in a variety of languages and with providers trained to consider a variety of positionalities. However, it may not be possible to incorporate all culturally sensitive treatments into this modality of treatment. Dodson & Schmidt (2015) highlight why psychotherapy may not work for First Nations groups in BC, and this is consistent with findings from the UK's IAPT program that was underutilized by racialized groups. This policy scores a **moderate** rating for the ability to incorporate culturally sensitive treatment options as a result.

The provision of virtual counselling can help those who live in rural or remote communities gain access to psychotherapy even when providers may not be physically in their communities – as already evidenced by the Foundry Virtual BC app usage across the province (Foundry, 2020), BounceBack's utilization rate (Government of BC, 2021a), and through findings from the ATAPS in Australia. Moreover, there is strong evidence to support not only that telephone and virtual therapy sessions are better than no treatment (Lamb et al, 2019), but also that they can be just as effective as in-person CBT sessions (Luo et al., 2020). It is important to consider, however, that some youth may have poor internet access: 6% of British Columbians do not have access to the internet (Statistics Canada, 2019), and those that do not are more likely to be in rural, remote, or Indigenous communities (Government of BC, n.d.c). Additionally, there is evidence that some Canadians (roughly 8%) are concerned about confidentiality while using virtual care (CPA, 2020), and we know that confidentiality is a significant priority

for youth. In some cases, then, the inclusion of virtual treatment options may not eliminate transportation or supply shortage barriers for those in rural/remote communities, and so this equity criteria also earns a **moderate** rating.

7.1.4. Cost

It is expected that the expansion of publicly funded psychotherapy would be an expensive policy for the Government of BC. As a reference, current investments for the Foundry Virtual BC app, which provides free virtual counselling, total $10.2 million over three years (Government of BC, 2021a). Given the extremely high demand for depression treatments, which have increased during the COVID-19 pandemic, and will increase even further given the elimination of cost barriers in addition to the fact that psychotherapy is offered to youth experiencing a variety of mental illnesses (thereby increasing demand even more), the initial costs of providing publicly funded psychotherapy would be high. This was evidenced in Australia, through their Better Access and ATAPS programs (Bartram, 2019). The overall rating for cost is **poor**.

7.1.5. Ease of Implementation

It is possible for this policy to be implemented through the BC Ministry of Health only, although it will involve external stakeholders – allied healthcare professionals in the private sector. A system for providers to submit billing claims will need to be established, as well as a system of regulating the number of sessions accessed by individuals and quality reporting, and allied healthcare professionals will need to be informed and trained on these systems and regulations. Since MSP is not a new program, there will be some level of experience in implementing such a system. The challenges in implementing this policy are likely primarily in terms of the length of time to implement such a policy. Another potential barrier to consider in the ease of implementation is that clinical counsellors in BC are not regulated (FactBC, n.d.; Lindsay, 2022); under current monitoring, anyone could claim to be a clinical counsellor. Standards for all providers covered under this program will need to be set before the policy is fully implemented. This criterion therefore earns a **moderate** rating.

7.2. CBT in Schools

7.2.1. Effectiveness

CBT is known to be effective at reducing diagnosis and symptoms of depression in youth, as well as preventing its onset (APA, 2019; Waddell et al., 2014). Group CBT has also been proven to be effective at both preventing depression and reducing the presence of depressive symptoms in youth (O'Brien et al., 2007), including in school settings (Moharreri & Heydari Yazdi, 2017; Pössel et al., 2018).[36] Since CBT will be provided to *all* students, regardless of depression diagnosis, we can expect that rates of depression will decline by treating youth who have depression as well as preventing the onset of depression cases that would have occurred later in life if this treatment had not been administered. It also provides these CBT-related skills to youth before they face aging out of CYMHS, in addition to many other life transitions.

Of course, it is unlikely that this treatment will prevent or eliminate all cases of depression in youth. Studies that compare universal school-based CBT programs to indicated school-based CBT programs found that indicated programs had stronger effects than universal programs (Calear & Christensen, 2010). [37] Interviewees, however, emphasized that prevention and early intervention strategies work to reduce the burden on the mental healthcare system regardless of whether it prevents all cases.[38] In other words, providing these treatments early, even before symptom onset, can lead to better mental health outcomes that will reduce the need for youth to seek care beyond the school setting, including primary care and the emergency department, and potentially reduced severity of cases that develop in the future. This works to increase the capacity of BC's currently overburdened mental healthcare system by reducing waitlists and allowing the healthcare system to focus on those who have more severe or complex cases that could benefit from more specialized care. The provision of a universal

[36] Additionally, it reduces and prevents the onset of anxiety symptoms (Stallard et al., 2014).

[37] Indicated programs refer to school-based CBT programs that are provided only to those that exhibit mild or early symptoms of depression (Calear & Christensen, 2010).

[38] One interviewee explained: *"we do not have those prevention programs that I mentioned [in place currently] and if we invested more in those, we could be delivering those in school, for example[. ….] We could reduce the burden, the number of kids getting depression, but we could also reduce the impact on the demands of clinical services, so they would be able to treat more kids."*

program could also be used to identify youth who should be referred for more specialized care.

Furthermore, the hiring and training of school-based mental healthcare providers itself increases the capacity of the BC mental healthcare system to provide services to youth directly. Given that the treatment will be provided in group settings, the capacity is increased even more, as a lower ratio of providers to student in schools is required compared to what would be needed for individual therapy. Thus, considering the efficacy of the treatment provided, its early intervention, and the significant increase in the supply of providers and capacity of the mental healthcare system more broadly, resulting from this policy, the criterion of effectiveness earns a **good** rating.

7.2.2. Stakeholder Acceptance

Group therapy has been recognized as stigmatizing for youth (Shechtman et al., 2016), and could therefore make it an unacceptable modality of treatment for school aged children. The fact that the treatment is provided to *all* students, regardless of mental illness diagnosis, will likely mitigate this (Calear & Christensen, 2010), which distinguishes itself from indicated and selected programs. In other words, students will not be singled-out as having a mental illness; psychotherapy will just become the norm in classrooms. Interviewees expressed how education is one of the best ways to reduce stigma on this issue. An additional positive externality of that, then, is that stigma regarding mental illness will go down. This is important considering that youth who have experienced psychotherapy are significantly more likely to believe that it works (Mehra et al., 2021), which could increase help-seeking behaviour if symptoms develop in the future. Moreover, this policy also meets youth where they are, eliminating the need for youth to travel to other locations or consider service hours to receive the treatment they need. This criterion earns a **good** rating as a result.

7.2.3. Equity

While this policy addresses CBT in schools, there is flexibility in incorporating culturally sensitive treatment options given that the program will be delivered in person within schools and there is a variety of treatment providers that can be hired to provide treatment. There is currently a lack of disaggregated data, however, to determine the

level and location of need for the vast array of potential culturally sensitive treatments. This creates a barrier to incorporating these treatments and this equity criterion therefore earns a **moderate** rating.

Since this policy inherently requires school-based mental healthcare professionals going directly to schools, this policy will address the needs of rural/remote youth by meeting them where they are at. A **good** rating is therefore earned by this criterion.

7.2.4. Cost

Integrated Child and Youth Teams is a new initiative implemented under the “A Pathway to Hope”, which consist of an integrated mental health team that will soon operate out of 20 school districts across BC and costs a total of $40.1 million over three years (Government of BC, 2021a). With this as a reference point, one can estimate that it would cost roughly that amount to provide CBT in all 60 BC school districts per year. This is well above the $6 million invested into the *Mental Health in Schools Strategy*, part of the “A Pathway to Hope” initiative, through Budget 2021 (Government of BC, 2021a). As a result, this criterion earns a rating of **poor** for cost.

7.2.5. Ease of Implementation

It is possible that multiple BC ministries may need to be involved in the implementation of this policy. First, educational requirements and training for school-based mental healthcare providers would need to be established for the implementation of this policy, likely through the Ministry of Health. Developmentally appropriate curriculum will also need to be established, likely by the Ministry of Education or the Ministry of Children and Family Development. The FRIENDS program in Ireland provides some guidance for the topics covered in each of the sessions, though, which could be used to inform BC’s course (Early Intervention Foundation, 2017). There may still be some challenges with this, however, considering that in order for CBT to be provided during school hours, changes to the overall school curriculum will be required to accommodate the hour-long lessons. The *Mental Health in Schools Strategy,* introduced in the “A Pathway to Hope”, is described as “a new approach to embedding positive mental health in all aspects of the education system, including culture,

leadership, curriculum, and learning environments" (Government of BC, 2021a, p. 11), which indicates an appetite for mental health issues to be addressed in schools. Importantly, though, is that a full course of CBT goes beyond "embedding" these discussions into current curriculum and instead would require the replacement of other coursework. This may therefore pose a challenge, as have other curriculum changes in BC (Gacoin, 2019), and should be considered in the implementation of this policy as a result.

On the other hand, having the material provided by mental health professionals rather than teachers may mitigate some teacher opposition, as recent survey results indicate that teachers currently feel as though they lack mental health related curriculum material and that they have insufficient time to prepare for their own lessons (Gacoin, 2019). With this, though, implementation would require the school-based mental healthcare professionals to be assigned schools or school districts for which they could rotate between each week to provide the lessons to students. While this may initially take time to establish, the ongoing administration of this policy will not be complex, and current BC initiatives such as Integrated Child and Youth Teams may serve as a blueprint for how this program could be implemented. Thus, the degree of complexity of implementation is **moderate** for this policy.

7.3. Care Passports

7.3.1. Effectiveness

Transitioning from the CYMHS to the AMHS is a significant barrier to effective care that is unique to the age group of focus within this study. Youth who age out of the CYMHS face higher rates of premature discontinuation of services which reduces the likelihood of successful outcomes. This is especially difficult given that the navigability of the mental healthcare system is weak, meaning youth do not know where to go to access treatment within the adult system, which is exacerbated both by their age and the nature of depression itself. Implementing a system of care passports that provide a detailed overview of the youth's treatment history and symptomology, while also providing resources on who to contact within the adult system, will help youth continue their treatment after aging out of care (such as through the previously noted uncoordinated free counselling services offered through "A Pathway to Hope").

Yet, this policy does not address the lack of supply of providers within the mental healthcare system. As a result, those who are unable to access care within the CYMHS, which is a significant amount given the long waitlists within the public sector, will not benefit from this policy. Additionally, this policy does not address any key barriers for youth in the private system, considering there is no inherent transition that occurs there, though it could be used by those in the private system if needed. Since there is such a high level of unmet need and this policy primarily benefits only those who access care in the public system, this effectiveness criteria earns a **poor/moderate** score.

7.3.2. Stakeholder Acceptance

This policy puts the burden of successful treatment on youth, who already face significant barriers in advocating for themselves, given their age, stigma, and symptoms. However, it reduces the burden of having to retell potentially triggering or emotional stories as well as remembering treatment history. The acceptability of this treatment option therefore earns a **moderate** rating.

7.3.3. Equity

Given that the care passports are available for any youth or provider to utilize, this policy allows for flexibility in the use of culturally sensitive treatments. This equity criterion therefore earns a **good** rating.

This policy improves access for those in remote/rural communities the same way that it increases access in other communities; by reducing the burden of transitioning from the CYMHS to the AMHS among those already accessing care in the public system. A system by which mental healthcare professionals can view care passports virtually could also benefit youth in these communities. Thus, this criterion earns a **moderate** rating similar to that of effectiveness.

7.3.4. Cost

Given that there is already a document for which these care passports could be modelled off of or incorporated into, this policy would not require major costs to develop. There are essentially no ongoing costs associated with the policy other than printing

costs. This policy is therefore extremely cost-efficient, and so it gets a rating of **good** for cost.

7.3.5. Ease of Implementation

It is likely that only one the BC Ministry of Health would be required to implement this policy. Additionally, since there is already Child Health Passports being used, the creation of a mental health passport is not likely to be a challenging endeavor. Once a PDF has been created for the care passports, similar to that of Child Health Passports, booklets would simply need to be printed at the various healthcare provider offices so that youth could take them as needed. Ease of implementation is therefore **good**.

7.4. Survey

7.4.1. Effectiveness

A survey of BC's grade 7 to 12 students will fill critical gaps in information that are needed in regards to youth mental health policy. Obtaining this data is critical in ensuring policies more accurately account for the unique barriers faced by various positionalities and can be used to determine the level of need for each treatment option, as well as where the greatest gaps are within the province and whether more mental healthcare providers will be required within the system. However, a survey will not itself increase access to depression treatments for youth. For this policy to be effective at reducing depressive symptoms within youth, the data must be made available and used by policy-makers and the Government of BC to inform current and future policies. Further, with the survey being an enhancement of the current Adolescent Health Survey conducted by MCS, which is distributed to students in schools (MCS, n.d.), the survey will not be available for the entire youth population as defined by this study. Thus, this option earns a **poor** rating for effectiveness.

7.4.2. Stakeholder Acceptance

As with all surveys, it is possible that the population may not participate, although with the survey provided to all BC students during class time, this may not be a major risk to ensuring an adequate sample size. Additionally, we know that youth may face

internal barriers, including informational gaps that hinder their ability to identify symptoms and stigma regarding admitting the severity of their symptoms or having depression at all, as evidenced by the literature review and interviews. Some interviewees, however, noted that they felt stigma was declining among this population and that mental health literacy was improving. Survey design measures such as strict confidentiality and questions that ask about symptoms specifically, rather than a diagnosis, can help mitigate these potential barriers. Other youth may value being able to share their experiences and the opportunity to inform changes that could benefit them. Overall, this criterion earns a rating of **good**.

7.4.3. Equity

Disaggregated data will better inform policy-makers on what culturally sensitive treatment options are needed and where. The survey can be distributed in a variety of languages and using a variety of methods so that it is accessible to all. Thus, this criterion earns a rating of **good**.

As with the previous equity rating, and since the MCS survey meets youth where they are at by being distributed in schools, this policy ensures that those in remote and rural communities are able to participate. The data can then be used to better inform policy-makers on the unique needs of youth in rural and remote communities. This equity criterion thereby also earns a rating of **good**.

7.4.4. Cost

The survey of BC students in grades 7 to 12 is conducted by the McCreary Centre Society every five years, with the next survey set to be distributed in 2023 (MCS, n.d.). Enhancing this survey to include more disaggregated questions would then likely have only marginal costs associated with it. Extra costs will be associated with translating the survey into other common languages to ensure that all youth are able to participate in the survey, which is essential. This policy earns a **moderate** rating for cost as a result.

7.4.5. Ease of Implementation

Distributing a survey is administratively complex for a government. Expanding on the MCS's Adolescent Health Survey reduces the complexity of implementation for the Government of BC, as the process for its implementation and distribution is already in place. However, the Government of BC will need to work with the MCS to ensure the survey is sufficiently enhanced to close the gaps in information currently experienced in BC, which will take time, cooperation, and collaboration. Thus, this criterion is rated **moderate/good**.

Chapter 8.

Recommendations and Implementation

Given the analysis results presented in Chapter 7, this study recommends the following bundle of policies to be implemented using a multi-staged approach.

First, in the short-term, the Government of BC should implement a system of care passports. Given the low degree of complexity of implementation, this policy can be implemented quickly and easily. While it only earned a poor/moderate effectiveness rating and a moderate stakeholder acceptance rating, the analysis indicated that it requires relatively little financial resources to address one of the main barriers to continued care faced uniquely by youth in the public system: it will work to help those who soon face ageing out of care have a better chance at gaining access to treatments within the AMHS. Informational resources provided in the booklet will help youth navigate the transition and detailed histories of their experiences and treatments will negate the need for youth to have to retell these stories to new providers.[39]

Additionally, this study recommends that the Government of BC, in the short-term, begin working towards implementing the administration of universal CBT programs in classrooms for students in elementary, middle, and secondary schools. This policy earned a poor cost rating; however, it was assessed to be the most effective policy at decreasing barriers to accessing effective care *and* at increasing the acceptability of treatment use by youth. The implementation of this policy will take more time than that expected of care passports, considering developmentally appropriate CBT curriculum will need to be created and integrated into school schedules, just as training of providers and the establishment of provider school assignments will be required as well. The actual delivery of CBT in schools should ideally occur in the school year immediately following the completion of these processes.

Next, in the second phase of policy implementation, it is recommended that a survey be conducted to gather reliable and disaggregated data on youth mental illness

[39] Since care passports would only be useful to those who are able to access care in the public system, a best practice that compliments this policy is the development of a centralized online resource that informs youth on first steps for accessing care in BC.

prevalence, treatment access and use, and on relevant personal factors that contribute to those outcomes. There is currently a critical lack of comprehensive data on this issue in BC, which prevents effective policy, especially when considering the diversity of needs within the population of youth experiencing depression in BC.[40] Since the MCS's Adolescent Health Survey is currently set to be distributed in 2023 (MCS, n.d.), it is unlikely that a full course of CBT could be provided to students in BC schools before the survey is completed. The 2023 survey results could therefore act as a baseline to compare with the results of the 2028 survey, in order to help assess the effectiveness of the policies as well as whether more action is needed.[41]

Finally, also in the second phase, it is recommended that psychotherapy for youth be integrated and expanded, by providing coverage through MSP, considering the severity of cost as a barrier for this age group and the impaired navigability associated with the currently fragmented public psychotherapy programs.[42] Further, as stigma and information-related gaps decline among BC's population, it is likely that demand for these services will grow, and so greater access to both public and private providers is necessary. Notably, with effective prevention and early intervention strategies in place, through the provision of CBT in BC schools, there may be reduced costs associated with providing MSP coverage for psychotherapy.

[40] While the survey that is recommended by the analysis is only distributed to students in grades 7 to 12, the Government of BC may consider extending the survey to include a larger portion of youth, or the entire population of BC, given that this gap in data does not apply only to youth (CIHI, 2019; MHCC, 2014).

[41] This could include informing whether universal CBT programming in schools should be shifted to indicated or selected programming.

[42] Providing coverage for psychotherapy through MSP to the entire population of BC should also be seriously considered, given that the barrier of cost does not apply only to youth (Moroz et al., 2020).

Chapter 9.

Limitations

The scope of this research was on increasing access to and use of depression treatments for youth in BC, which was reflected in the policy options presented. There are many variables in the development of depression, however, and it follows that there are an equally vast number of ways that depression among youth can be addressed. Social determinants and quality of treatment provision are also important considerations in addressing depression among youth. While social determinants were out of scope for this paper, there were attempts to consider quality of services by presenting treatment options that are evidence-based, although the success of these treatment options still rests on the proper provision of those treatments. Interviewees indicated that they felt that the quality of services in BC, once accessed, were primarily good. Training and quality were therefore not pursued as barriers in this study, but it would be valuable to hear from youth directly on the quality of depression treatments provided in BC.

Similarly, the lack of engagement with youth who have lived experiences in interviews, due to the short timeframe available for research, presents another limitation of this study especially considering how critical youth-tailored services are in use and access of treatments. Inferences from the literature and interpretations by providers on what youth want and need were used to inform the Stakeholder Acceptance criteria in the analysis, in recognition of its importance, but further studies should be conducted to confirm youth preferences.

Finally, best efforts were made to select interview participants that were geographically diverse and representative of each of the potential avenues for treatment that could be accessed by youth. This proved to be a challenge, though, evidenced by the fact that only three interview participants were from BC regions located outside of Metro Vancouver. Additionally, many public providers did not respond to interview requests – likely another indication of the inundated demand for their services.

Chapter 10.

Conclusion

Canada is currently facing a mental healthcare crisis, which has been exacerbated by the COVID-19 pandemic, and in which youth are disproportionately affected. In BC, the system has been described as reactionary and crisis-driven, which is the least effective way to manage depression among youth, and underfunding, fragmentation, and stigma have created significant barriers for youth experiencing depression – in all their diversity – to accessing and using effective treatment. In response, BC, with the support of the federal government, has recently made historic investments into youth mental healthcare and a number of programs have already been initiated. While a step in the right direction, the extent to which chronic underfunding, especially in youth-tailored mental health services, has persisted up until this point makes it hard for these investments to go as far as is needed. Effective depression prevention programs and truly integrated services are still missing from BC's current mental health roadmap.

This study aimed to assess key barriers faced by youth experiencing depression in BC and provided a multi-criteria analysis of four policy options to address them. The subsequent policy bundle that was recommended aligns with at least three of the goals of BC's "A Pathway to Hope", as they will effectively increase prevention and early interventions in a systematic way through the school system; promote the seamless transition of treatment for those who age out of CYMHS using a system of cost-efficient care passports; and gather the data that is essential to providing equitable access to culturally safe and effective care. Integration of publicly funded psychotherapy under BC's Medical Services Plan will also help meet these goals.

Importantly, this study has implications for how mental healthcare can be approached in other Canadian provinces, which struggle with similar challenges. All provinces across Canada have seen how the stigmatization and neglect of mental illnesses, including depression, have not made them go away. Rather, they have only become more prevalent and have major costs to both individuals and society; we need not look further than the overdose crisis in BC and suicide rates among youth across the

country. The COVID-19 pandemic demonstrates the unsustainability of this practice, especially when unexpected shocks are faced by the healthcare system. Concerted efforts should be made to make mindful paths forward in ways that support both patients and healthcare workers. Ultimately, while these policies will be costly for the government, the payoffs will be immense: ranging from increased productivity within the economy, reduced costs in the healthcare system, and, most importantly, improved quality of life for the youth who represent the future of British Columbia.

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Appendix. DSM-5 Criteria for MDD

In BC, and in many other parts of the world, diagnosis of MDD is made through clinical interviews guided by the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* (5th Edition), also known as the DSM-5 (Government of BC, 2013). The DSM-5 outlines the criteria for diagnosis of a major depressive episode, which is that five or more of the following symptoms must be present during a two-week period:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (can be irritable mood in children or adolescents),
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation),
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% body weight in a month) or a decrease or increase in appetite nearly every day, (can consider failure to make expected weight gain in children),
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, nor merely subjective feelings of restlessness or being slowed down),
6. Fatigue or loss of energy nearly every day,
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick),
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others),
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (APA, 2013).

These symptoms must represent a change from previous functioning and at least one must be either depressed mood or loss of interest or pleasure (APA, 2013). The symptoms must also cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and the episode should not be

attributable to the physiological effects of a substance or to another medical condition. The Patient Health Questionnaire-9 (PHQ-9) is used to identify the number and type of symptoms, which determines whether the patient meets the criteria for depression and, if so, the severity of the case, ranging from mild to moderate to severe (Government of BC, 2013).