# FROM INSTITUTION TO COMMUNITY: EXPLORING THE CHALLENGES OF CARING FOR YOUTH WITH SEVERE MENTAL ILLNESS

by

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# Abstract

Care for youth with severe mental illness in the province of British Columbia is shifting from institutions to communities. This shift has not been accompanied by sufficient resources, in the form of services, facilities and caregivers for the youth, their families and communities. A review of literature identified barriers to care as well as different models of care – residential-based and community-based. Quantitative data helped establish need and available resources. Major findings show that there are not enough mental health services but also that implementation of new initiatives typically does not include a community perspective. The shift from institution to community requires a better understanding of communities, a greater knowledge of their resources and their sustainability. It also requires a central role for youth, their families and the greater community in all the stages of the actual mental health reform.

# Executive Summary

Reform of children and youth mental health care policies and practices is presently taking place in British Columbia. The provincial government, with different stakeholder input, has developed a plan that involves the transfer of care for youth with severe mental illness from institutions to communities. This study looks at the lack of community-based resources to facilitate care for this high-risk population. Resources, in this context, are define broadly as encompassing mental health services as well as family and friends, mental health associations and wide-ranging community groups. It is important to assess community capacity as the shift from institutionally-based care to community-based care is firmly in progress. Youth with severe mental illness are still referred to tertiary care (residential care) which, in British Columbia, is presently offered by one facility located in the Lower Mainland. Close to 10,000 youth in the province of British Columbia experience severe functioning impairment due to mental illness. Identifying and addressing barriers to their care is thus a significant policy issue for British Columbia.

A review of the literature identifies barriers to care and looks at different models of care for people with mental illness. The barriers to care are at three levels: 1) personal, such as stigma, family and economic factors; 2) systemic, which includes lack of financial and human resources, lack of information, and institutional territoriality, and; 3)environmental, namely distance and weather. The study examines the Community Resource Base Model, the Systems of Care, and the Wraparound models as well as some specific community-based interventions to draw out ways in which these models reduce the barriers to care using a community perspective.

The admission data from the only residential provincial facility was used as well as some of the data from a self-reported youth survey in the province, to establish need and services available. Some of the findings are lack of residential facilities, lack of trained health practitioners, the lack of resources for community-based tertiary care, the difficulty in shifting the discourse and practice from a bureaucratic, institutional and medical perspective to a community one, and fragmentation. An overarching finding is the lack of inclusion of youth, families and communities in the planning, delivery and outcome evaluation.

The study proposes strategies that would include youth, families and communities in the provincial mental health reform as experts and not only service users and service managers. To this end, the provincial government needs to use a community perspective lens. This requires investment in community-based strategies and these are articulated in four policy options:

1. Development and implementation of a child and youth mental health provincial communication strategy.
2. Reinstatement of the external advisory committee for child and youth mental health.
3. Redirecting funds towards capacity building at the local level.
4. Province-wide survey of community resources available for youth with mental illness.

The recommendation is to proceed with all policy options starting with the reinstatement of the external advisory committee for child and youth mental health to give a voice to youth, families and communities in a process that is already underway. The provincial communication strategy is essential and should be ongoing, as the government embarks in an important change in direction for the care of youth with mental illness. It is timely to distribute widely information about mental illness, the resources available and what mental health consumers and their parents can expect in the shift from institutional-based to community-based care.

# Dedication

À Colin, dont l'amour se traduit par un appui indéfectible.

À papa qui m'a montré le chemin.

« La persévérance est un talisman pour la vie. » Proverbe africain.

# Acknowledgements

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# Glossary

| Term | Definition |
|---|---|
| Consumer | In mental health in Canada, consumer is the preferred term to refer to people with mental health problems or with a mental illness who have used mental health services. |
| Evidence-based practice | Evidence-based practice refers to a body of scientific knowledge about service practices, including referral, assessment, outcome management and assessment, quality improvement practices, and case management. The goal of evidence-based practice is to ensure that the most effective treatment approaches are communicated and used to help youth and families. |
| Impairment | Also functional impairment. An individual's reduced ability to perform usual daily activities. A number of measurements exist to gauge a person's level of functioning and level of functional impairment. |
| Inpatient | Assessment, diagnosis, treatment, stabilization and short-term rehabilitation of people with serious mental illnesses admitted to a hospital psychiatric unit. |
| Primary Care | First level of contact individuals, the family and community has with the health system. A physician provides it, be it via an emergency room visit, office appointment or house call. |
| Secondary Care | Also referred to as acute care. Diagnostic and therapeutic health care (in medical disciplines, including psychiatry) provided by health care professionals, usually in a hospital setting and for a short duration. |
| Tertiary Care | Specialized intervention delivered by highly trained staff to individuals with problems that are complex and refractory to primary and secondary care. This type of care should require referral from secondary care. |

# 1 Introduction

In British Columbia, an estimated 200,000 children and youth suffer from a mental illness (Waddell, Hua, & Sheperd, 2002, p.4) and approximately 10,000 youth suffer extreme impairment.[1] Despite these high numbers, child and youth mental health is an area that has not received much attention, until recently. Service delivery to youth with severe mental illness in the province of British Columbia faces many challenges, one being the shift from residential care to community care. The research informing the current mental health reform in the province shows growing evidence that community-based approaches are more effective in improving mental health (Waddell, McEwan, Sheperd, Offord & Hua, 2005, p. 231). However, many questions remain as to the community's capacity and ability to deliver mental health treatment and care, as this sector remains underfunded (Goering, Wasylenki & Durbin, 2000, p. 346) and undefined (Labonté, 1995, p. 167). The goal of decreasing reliance on institutional care includes a strategy to increase community resources. This study looks at the challenges facing institutions and communities in caring for this high risk, distressed population and suggests that the shift cannot produce desired outcomes until community-based resources are truly recognized as valuable, sustainable, and are treated and funded accordingly

The policy problem is that there are too few community-based resources to facilitate the care of youth with severe mental illness in British Columbia. Resources is to be interpreted broadly to describe mental health services but also, and just as importantly, to describe friends and family and community-based initiatives that enable youth and their families to access support, advocacy and counselling. The lessons learned from the first wave of deinstitutionalization of the adult population with severe mental illness that occurred from 1960 to 1980, confirm the need to invest in building community capacity to ensure quality and continuity in care. Youth in this project are between the ages of 12 and 17. Severe mental illness

[1] Impairment or functional impairment is an individual's reduced ability to perform usual daily activities. A number of measurements exist to gauge a person's level of functioning.

refers to the experience of severe persistent behavioural difficulties or psychiatric disorders that affect the youth's ability to function at home, at school and in the community.

The introductory sections of the study define the policy problem, briefly describe the target population and provide background on the current provincial child and youth mental health strategy and service delivery. The following section offers an overview of the literature on the barriers to care, at the personal, systemic and environmental levels, and on some of the models of care, institution-based as well as community-based. We look more closely at the only designated specialized tertiary care facility in British Columbia – the Maples Adolescent Treatment Centre which offers programs and services on a residential basis as well as in the community. Using data from a population-based survey of youth in the province and admission data at the provincial facility, complemented with other sources of information, we map out the resources needs of youth and their families in the province and the resources available to them. A discussion draws inferences and points out significant relationships that will guide the development of policy alternatives. The last sections evaluate policy alternatives and summarize with policy recommendations.

# 2 Policy Problem

In the province of British Columbia, an estimated 20% of children and youth (or approximately 200,000), experience mental disorders causing significant impairment before they reach 18 years of age. A total of 5% of children and youth suffer extreme impairment (50,000) in BC (Waddell, Hua & Sheperd, 2002, p. 4). No other illness damages children and youth so seriously (Glied & Cuellar, 2003, p.40), and, if not treated, will most likely persist in their adult years. Mental illness affects all aspects of their lives at home, at school, with their peers and in the community in general. The children and youth experience varying degrees of distress often compounded by the difficulty for families in finding appropriate information and services for assessment, treatment and support.[2]

Before the medicalization of psychiatry, which started in the 1970s, youth psychiatry programs were in child development clinics staffed originally by social workers who were later joined by paediatricians, psychologists, psychoanalysts, and psychiatrists (Pumariega, Winters & Huffine, 2003, pp. 402-403). In the late 1960s and early 1970s, adolescent mental health services moved towards the more hospital-based, tertiary care model of delivery. In Canada, provincial and regional residential facilities for youth, such as the Maples Adolescent Treatment Centre (MATC) in British Columbia, were established. According to Pumariega et al. (2003, p.402) this left community health centres without significant psychiatric input as many specialized practitioners were moving where their services were most required. As resources (financial, human and others) were primarily invested in these facilities, the development of children and youth's services was neglected. In the early 1980s, advocacy groups started exposing the consequences of under funding and under developing community-based mental health services for children and youth and their families. In 1982, Jane Knitzer published the book *Unclaimed Children*, which documented the lack of community-based care and its impact. Her book had a great influence in bringing about a major change in the organization of mental health services for children and youth.

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[2] This project looks at youth (12-17 years of age) but a lot of the research in mental health does not differentiate between children and youth. For the purpose of this document, the term youth will be predominantly used.

In the late 1980s, in British Columbia, decentralization of mental health services brought about an initial evaluation of residential programs that translated into shorter stays and higher admission rates (Verlaan, 1991 p.5). Now, in the context of the child and youth mental health reform, important factors in re-evaluating institutional care are its cost (Moretti, Emmrys, Grizenko, Holland, Moore, Shamsie, & Hamilton, 1997; Berland, 2001) and the lack of clinical evidence of its effectiveness (Moretti et al., 1997, p. 640; Wadell et al., 2005, p. 231). Hair (2005, p. 552) in a review of research on residential treatment outcomes points out that although treatment for high risk youth in a residential setting was a common strategy, it "operated under a shadow of controversy", mainly due to mixed opinions about separating youth from their families. Finally and quite significantly, a review of the Mental Health Act in 1989 provided adolescents with protection of their rights so that is was no longer possible to detain them in secure units simply on the basis of guardian consent (Moretti et al, 1997, p. 640). All these observations mean that there is even more pressure to increase and improve community-based care and to decrease reliance on institution-based care.

The past 20 years have seen major changes in child and youth psychiatry due to scientific advances in child and youth mental health, social changes and mental health policies (Glied & Cuellar, 2003, p. 40). In Canada, it was only in the early nineties that mental illness of children and youth was recognized as a significant public health issue (Health and Welfare Canada, 1991, as cited in the Child and Youth Mental Health Plan for British Columbia, revised 2004, p. 1). In June 2001, the premier of British Columbia appointed a Minister of State for Mental Health who led a joint planning initiative for children and youth's mental health with the Ministry of Children and Family and the Ministry of Health (then Ministry of Health Services). This initiative came at a time when the shift from residential/inpatient care to community/outpatient care for people with severe and persistent mental illness had brought the gradual closure of large provincial or regional adult mental health facilities such as Riverview Hospital in British Columbia. New models of community care were implemented for adults and began influencing the direction of care for youth with severe mental illness.

The problem is that there are too few community-based resources to facilitate the care of youth with severe mental illness. Much rests on defining resource needs and how are they to be used to care for this high-risk population. Just as the assumptions about the provision of adequate resources from the hospital/institution model into the new community care model are questioned (Goodwin, 1997. p. 149) so is the ability for service providers to use a community perspective to

develop and implement these new models (Baily, 2004). The Canadian Mental Health Association (CMHA), while recognizing the importance of mental health services, proposes a broader definition of resources through its Community Resource Base model. In this model, family and friends, consumer groups[3] and generic community groups are resources that are important to the consumer (Pape & Galipeault, 2002, p. 10). While the CMHA recognizes the importance of health services it equally values the other resources as essential components of quality care. One objective of the Community Resource Base model, described in more detail later, is to counter the prevailing emphasis on the medical/clinical perspective in mental health care. Other community models address this important shift in philosophy but the inclusion of a community perspective has yet to be implemented in a sustainable way.

This is an important policy issue for many reasons. First, it deals with the care of a population that is severely emotionally impaired who often needs specialized services along with a mix of other support services over time. Berland (2001, p. 40) and Pumariega, et al. (2003, p. 404) argue that a successful plan targets the most severely ill population. Secondly, the province of British Columbia is in the second stage of implementation of a child and youth mental health plan. The focus of this second stage is on capacity building and it is important to see if the lessons learned from the adult deinstitutionalization movement are informing the present decisions. Finally, empowering individuals and groups by involving them in the development and improvement of resources they need to care for their youth, ensures sustainability and continuity while creating safer communities.

[3] In mental health in Canada, consumer is the preferred term to refer to people with mental health problems or with a mental illness who have used mental health services.

# 3 Methodology

This study uses different approaches to examine the policy problem. A review of the literature identifies the different barriers to care in the mental health field as well as the different models of service delivery, community-based and institutional. Recent documents produced by the provincial government as well as website contents of the different ministries and not-for profit organizations related to youth mental health provide a detailed picture of the current situation in the province.

To establish the demand for mental health services, we used some of the data from the 2003 Adolescent Health Survey, conducted by The McCreary Society. This is a population-based survey of 30,000 youth in the province's secondary schools. The sections on emotional health helped establish mental health needs of youth in the province and compare self-reported emotional distress to the mental illness prevalence identified in the literature. The 2003 Adolescent Health Survey also documented connectedness as an important variable in emotional health.

On the supply side, we look at the admission data of the Maples Adolescent Treatment Centre (MATC) that has been gathering admission data using a computerized system called Management Analysis and Reporting System (MARS). Unfortunately, data entry is not as complete as it could be, but there is enough information to have a picture of the admission patterns by administrative area for two years. We look at region of origin, gender and more specific program admissions.

Complimentary to this data, we used statistical data from BC- Stats to establish population by geographic area and by age to relate it to the admissions at the MATC. Information on the supply side, primary care physicians and psychiatrists, adolescent psychiatric beds in general hospitals, and other services, was gathered partly through Internet searches.

# 4 Context: Mental health needs and the policy environment

This section examines the population of youth with severe mental illness in the province. We initially broadly define severe mental illness and then look at the prevalence of mental disorders in general, and more specifically as they pertain to youth in British Columbia. A brief historical overview of the focus of mental health care for youth in recent years is followed by a description of the current situation in the province, including a brief description in this section of the Maples Adolescent Treatment Centre (MATC). A more detailed description of the programs and services at MACT is in section 4.2.3

## 4.1 Target Population

The target population for this research consists of British Columbia youth between the ages of 12 and 17 with severe mental illness. As McEwan and Goldner (2001) point out, there is no definition of severe mental illness in Canadian federal legislation. They suggest that persons with severe mental illness are "both individuals with severe mental disorders and those with less severe but socially and economically significant disorders." The people in the first group experience profound symptom severity which affects their ability to function in a persistent or reoccurring way which usually means that they require some external resources to cope with daily living. The second group has less severe symptoms and disability but still experiences substantial functional impairment. The American Psychiatric Association's Diagnostic and Statistical Manual (DSM) defines "mental disorder" as an emotional, behavioural, or brain-related condition that causes moderate to severe impairment in functioning (in Waddell, McEwan, Hua & Shepherd, 2002, p 6). I use the terms mental illness and mental disorder interchangeably.

Mental health does not imply the absence of mental illness but rather refers to the individual's capacity to interact with others in ways that promote subjective well being, optimal development and the use of mental abilities. Also included in the definition of mental health is "the achievement of individual and collective goals consistent with justice and the attainment and

preservation of conditions of fundamental equity" (Health and Welfare Canada, 1998, as cited in Pape & Galipeault, 2002, p. 6). In other words, all people, including people with mental illness should have equitable access to basic rights such as education, housing, income and work.

Establishing the prevalence of mental disorders remains difficult, but recent studies in the US suggest overall prevalence rates for child and youth mental illness of 15 to 19 percent, with 3 to 8 percent for severe mental illness and emotional disturbance (Pumariega et al., 2003, p. 400). The Mental Health Evaluation & Community Consultation Unit (Mheccu) at the University of British Columbia, suggests in a 2002 report that as many as 20% of children and adolescents in the community may have moderate or severe mental illness.[4] Table 1 shows the prevalence rates of specific disorders as compiled by the Mheccu. It should be noted that the degree of impairment cannot be implied by the disorder. Also noted in this research is the presence of comorbidity, the occurrence of two or more disorders, which can affect between two- thirds and as many as three-quarters of children and youth with a mental disorder.

As it is beyond the scope of this project to look at practices for effective interventions for disorders, we define here only three of the most prevalent disorders: anxiety disorder, attention-deficit/hyperactivity disorder, and conduct disorder. It will useful in understanding the need for secure setting in service delivery for youth with some of these disorders. Anxiety disorders, the highest prevalence, have both psychological and physical symptoms and can be panic disorders, obsessive compulsive or posttraumatic stress disorder, social phobias or other phobias.[5] Attention-deficit / hyperactivity disorders (ADHD) "involves a persistent pattern of inattention and or hyperactivity that is inconsistent with developmental level and intellectual abilities, and that causes distress and impairs functioning in two or more settings" (Waddell, Hua & Sheperd, 2002, p.10). Conduct disorders, the single most prevalent and costly (Moretti et al, 1997, p. 637), is defined as "a persistent pattern of anti-social behaviour where basic rights of others or other age-appropriate norms are violated, and where functioning is impaired in multiple domains" (Waddell, Hua & Sheperd, 2002, p.14).

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[4] Mheccu receives funding from the Mental Health and Youth Policy and Program Support and the BC Ministry of Children and Family Development as part of a comprehensive child and youth health planning process which leads Child and Youth Mental Health Plan.
[5] Information from the Anxiety Disorder Association of BC.

*Table 1 Prevalence Rates for Mental Disorders*

| Disorder | Estimated Prevalence (%) |
|---|---|
| Any anxiety disorder | 6-8 |
| Attention-deficit/hyperactivity disorder | 2-10 |
| Conduct disorder | 2-6 |
| Substance abuse | 0.1-6 |
| Any depressive disorder | 1-4 |
| Obsessive-compulsive disorder | 0.2 |
| Autism | 0.2 |
| Schizophrenia | 0.1 |
| Bipolar disorder | 0.1 |
| Any eating disorder | 0.1 |
| Tourette's disorder | 0.1 |
| One or more disorder(s) | 14-27 |

*Source: Mental Health Evaluation and Community Consultation Unit, 2002.*

According to the World Health Organization (2003, p. 4), worldwide, suicide is the third leading cause of death among adolescents. In Canada, suicide accounts for 24% of all deaths among those aged 15 to 24. Many disorders have their onset in adolescence: schizophrenia, anorexia and major depressive disorders.

In the province of British Columbia, it is estimated that close to 10,000 youth between the ages of 12 and 17 suffer from a severe mental illness. Table 2 gives the breakdown of the number of youth by region.[6] The regions are the provincial administrative divisions for the Ministry of Children and Family Development that are the same as those of the Ministry of Health[7]. Youth as a percentage of total population shows that the highest percentage of youth is in the North, while the lowest percentage is in the Vancouver Coastal area. Finally, the last row in the table, gives an approximation of the number of youth per region who suffer from a severe mental illness. The lowest estimate of the prevalence of severe mental illness among this age group (3%) is used. This brings the total number of youth with severe mental illness to just over 9,700. This is a very conservative estimate. If the highest estimate of prevalence is chosen (5%), then the population of youth suffering extreme impairment raises to over 16,000.

[6] Not shown in Table 2, is the ratio of males to females. For all regions, females represent approximately 49% of the population.
[7] A map of administrative regions can be found in Appendix A.

*Table 2. Estimate of youth population and youth with severe with mental illness by region*

| Region | Total population (adult & youth) | Total 12-17 | % of total regional population | % of total provincial youth population | 3% of youth with Severe Mental Ilness |
|---|---|---|---|---|---|
| Fraser | 1,466,328 | 118,098 | 8.06 % | 36.4% | 3,543 |
| Vancouver Coastal | 1,040,614 | 63,352 | 6.09% | 19.5% | 1,900 |
| Vancouver Island | 723,002 | 55,341 | 7.65% | 17% | 1,660 |
| North | 307,566 | 29,812 | 9.69% | 9.2% | 894 |
| Interior | 717,012 | 57,830 | 8.06% | 17.8% | 1,735 |
| Provincial | 4,254,522 | 324,433 | 7.63% | 100% | 9,732 |

*Source:Population estimates (1986-2005) and projections (2005-2031) by BC STATS, Service BC, BC Ministry of Labour and Citizens' Services.*

The prevalence of youth mental disorders exceeds the specialized treatment capacity in most jurisdictions. According to Waddell et al. (2005, p.226), fewer than 25% of children with a mental disorder receive specialized treatment services. There is no question that the needs of many youth are not being met. The pain and suffering of severe mental illness in young people also affects their families, friends and communities and, for some, will continue into adulthood. For some of these youth, the severity of social, emotional or behavioural difficulties along with the need for community protection necessitates out-of-home placement in a residential treatment centre. Others can function in a community setting when appropriate resources are available. What is clear is that the more severe the mental illness, the more specialized the type of care is required, but according to Wasylenki et al. (2000, p. 180) it does not have to be delivered on an inpatient basis (residential or psychiatric unit in a general hospital). That might be the case, but then the level of resources available to the youth and to his or her family is even more essential. The decisions about the type of care are made by the youth, the family and by health practitioners and are influenced not only by the youth's needs but also, more often than it should, by the level of services and resources available. A continuum of care is needed for all youth with a mental

illness. It implies a range of care for those with severe disorders requiring specialized care to those with less severe disorders and requiring less invasive intervention, is needed to respond to the different needs and different situations.

## 4.2 In British Columbia

A major reorganization of the province's mental health services for youth and children is now underway. With the new millennium, the province embarked on a large-scale consultation of different stakeholders while researching evidence-based practices.[8] In the summer of 2005, the Minister for Children and Family Development announced that the sector responsible for children and youth mental health would move to the Ministry of Health. Within a week, the decision was reversed. Caring for children and youth with mental illness is complex partly because of the number of ministries directly involved. The number of stakeholders means that accountability and coherence are hard to achieve. The apparent goal of the reorganization was to consolidate all mental health services under one ministry, but children and youth advocates worried that the needs of this population would not be priorities and the responsibility of children and youth should remain with a ministry directly responsible for them. There is a need for a formal structure to ensure coordination at a provincial level and to be integrated in the MCFD's Child and Youth Mental Health Plan (called the Plan). In this section, we look at the Plan and give an overview of mental health service delivery.

### 4.2.1 Child and Youth Mental Health Plan

In the early 1990s, it became evident that mental health policies and programs had largely focused on the treatment of the adult population. The province of British Columbia was struggling, like most Canadian jurisdictions, to provide adequate services to children and youth with mental illness. Studies determined that one in six children and adolescents with mental illness received some form of speciality mental health service (Child and Youth Mental Health Plan, 2004). Changes to the Mental Health Act in 1989 broadened the criteria for involuntary treatment, improved provider's communication with family members as well as patient's rights

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[8] Evidence-based practice (EBP) refers to "a body of scientific knowledge about service practices, including referral, assessment, outcome management/assessment, quality improvement practices, and case management." (Hoagwood, Burns, Kiser, Ringeisen and Schoewald, 2001, as cited in Barwick, Boydell, Stasiulis, Ferguson, Blasé and Fixen, 2005, p.7). Waddell, Godderis, Wong and Garland (2004, p. 16) define evidence-based practice in the health field as "the ongoing process of learning about and using research evidence to guide practice." The goal of EBP is to ensure that the most effective treatment approaches are communicated and used to help youth and families.

and allowed community-based committal for chronically ill individuals (Berland, 2001; Moretti et al. 1997, p. 640).

In 2001, the appointment of a Minister of State for Mental Health was the first step towards developing a framework for service organization and delivery. A joint effort between the Ministry of Health and the Ministry of Children and Family Development undertook a review of the mental health services for children and youth. As part of the process, a province wide consultation took place with representatives from several of the ministries involved with children and youth (MCFD, MH, Ministry of Education, etc.), from Aboriginal communities and from ethnocultural organizations. The top four priorities for the Ministry of Health and the Ministry of Children and Family Development across program staff are the following: a) mental health residential resources; b) transition services for youth aged 15-24 years; c) policies, procedures and operational standards, and; d) identifying and serving young population.

An External Advisory Committee for Child and Youth Mental Health was also established in 2001. The mandate of this committee was to monitor and advise on the province's progress towards resolution of the mental health issues identified in the process, including the development of the Child and Youth Mental Health Plan (called the Plan). The Committee was in place for only two years in which time it released two reports.

As stated in the Plan, there are many challenges. The Plan noted that increasing clinical services is not sufficient. Coordinated approaches are required and the Plan identifies four levels of actions as the blueprint for change:

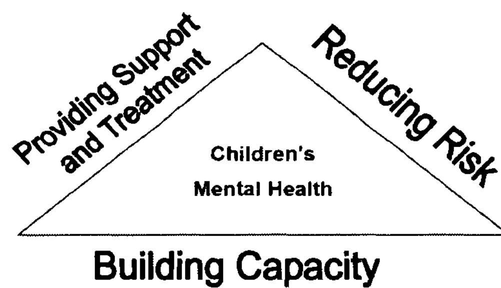
1. More timely and effective treatment and support services are needed for children with serious mental illness;
2. Programs are needed to reduce risk and prevent and mitigate the effects of mental illness;
3. New efforts are needed to improve the capacities of families and communities to prevent and/or overcome the harmful impact of mental illness in children;
4. Better systems are needed to coordinate services, monitor outcomes, and ensure public accountability for policies and programs. (Child and Youth Mental Health Plan for British Columbia, 2004, p.i).

Based on a review of the literature and on developments in other jurisdictions, the Plan suggests that the most promising strategies should use both population and individual interventions. It also stresses that the Plan has to be in line with the MCFD's strategic shifts that call for more community involvement, community capacity building, and community-based service delivery (Child and Youth Mental Health Plan of British Columbia, 2004, Appendix D). There is no doubt that the next decade we will continue to see the continuation of the shift to community care (Goering, Wasylenki & Durbin, 2000, p. 235).

To address the elements of the blueprint for change, the Plan proposes intervening in three key areas. Figure 1 illustrates those components. The first one, providing support and treatment, suggests the need for a range of evidence-based approaches and programs with an emphasis on delivery in the youth's home community and with a multidisciplinary model. To this end, efforts are directed at recruiting and retaining individuals from a variety of professions distributed across the province and supported by specialized expertise when necessary. Reducing risk, the second key component, has two aspects: reducing risk factors, individual or environmental, and increasing protective factors. The third key component of the plan involves building capacity at the family and community levels. Supporting families, helping them develop new skills and involving different community actors in the care of the youth with a mental disorder are some of the strategies proposed to build capacity.

All four components of the BC's approach to mental health have a strong community focus. Support and treatment requires trained mental health practitioners but also includes the support to the youth and his or her family from school, friends and community-based groups. Early intervention and prevention along with community participation reduces personal risks. Reducing barriers to care help mitigate environmental risks factors. Such barriers include lack of services, but an efficient strategy requires much more than this. Section 5.1 discusses these barriers and possible responses. Building capacity focuses mostly on families and communities and, finally, service coordination and accountability involve consumers.

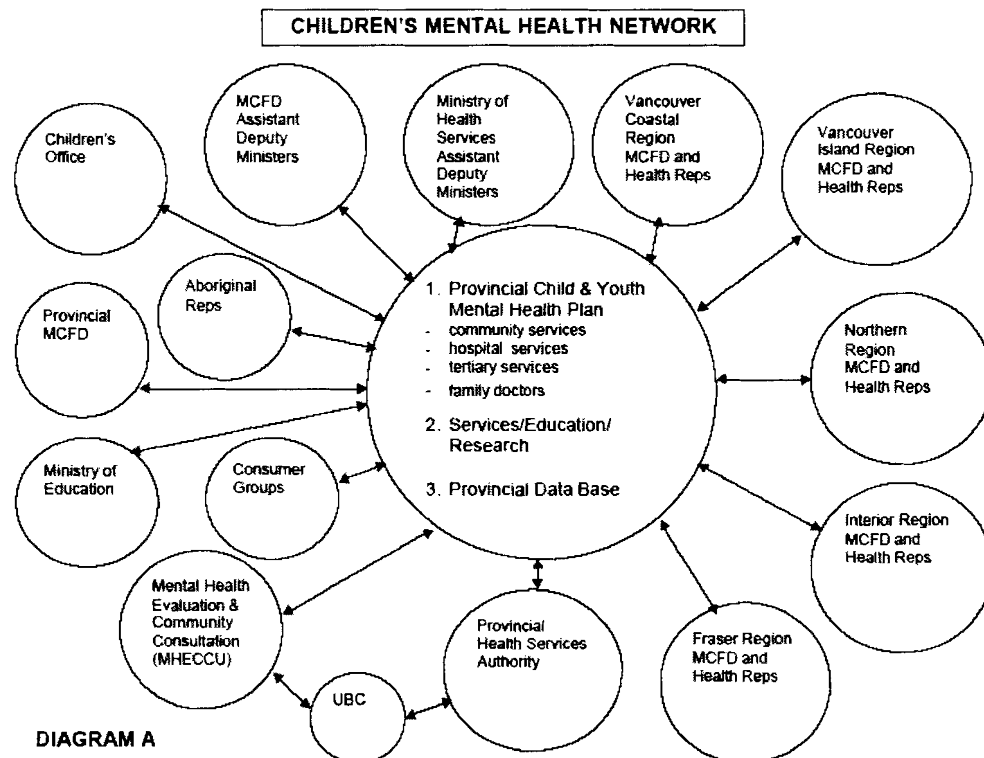
*Figure 1. Three Key Components in Children and Youth Mental Health in BC*




*Source: Child and Youth Mental Health Plan for British Columbia, Revised July 2004, p11.*

Another important outcome of the process surrounding the development of the Plan is the creation of a formal Provincial Child and Youth Mental Health Network (Figure 2) that has the responsibility of overall system accountability that includes coordinated planning and service delivery, locally, regionally and provincially. The recognition of the difficulties of providing a continuum of care motivated the creation of the network. Some examples of the more specific difficulties are providing transitions between acute care services and community, and between youth and adult services. Included in the Network, for the governmental sector, are representatives respectively from the Ministry of Children and Family Development and the Ministry of Health, for each region, and for provincial services. The Ministry of Education is also present. UBC and the Mental Health Evaluation and Community Consultation Unit (Mheccu) represent the research partners. The community partners are consumer groups and aboriginal representatives.

*Figure 2. Provincial Child and Youth Mental Health Network*




*Source: Child and Youth Mental Health Plan for British Columbia, Appendix E.*

### 4.2.2 Mental Health Service Delivery System

**Governmental**

The provincial child and youth mental health networks illustrate that there are numerous ministries and practitioners involved in the delivery of services. The Ministry of Children and Family Development, under Provincial Services Branch, serves children and youth through three programs: Maples Adolescent Treatment Centre (MATC), Youth Forensic Psychiatric Services (YFPS) and the Child and Youth Mental Health Services (CYMHS). The MATC is a specialized tertiary mental health facility offering residential (32 beds) and community treatment programs (16 treatment spaces) to adolescents with severe mental and behavioural disorders. A more detailed description of the MATC, its programs and services follows this section. With a budget of $ 12.5 million, the MACT represents 14% of the total expenditures of the provincial services branch of the Ministry of Children and Family Development. YFPS, with an annual budget of $13.1 million, provides assessment and treatment services for young offenders in the community and in custody. It also has an inpatient assessment unit for youth remanded for a court-ordered

assessment. CYMS, with an annual budget of $43 million, offers a community-based specialized mental health service, a network of mental health staff and sessional psychiatrists and a program of 170 contracted service agencies. CYMS is presently in the process of hiring 80 new mental health professionals such as psychologists, nurses, psychiatric nurses and clinical social workers.

The Ministry of Health is responsible for medical services, community-based adult mental health programs and all acute care psychiatric programs including hospital services for children and youth. This translates into emergency services for children and youth experiencing psychiatric crisis and 101 specialized inpatient hospital beds for children and youth with mental disorders requiring stabilization or intensive assessment and treatment. These beds are located in hospitals in major centres with roughly half designated for adolescents.

The Ministry of Education is a partner in the Youth and Child Mental Health Network and, together with other ministries has developed prevention programs in the schools. One such program is the "Friends project", sponsored by MCFD and offered in schools as a risk reduction strategy., The FRIENDS initiative targets prevention of depression and anxiety disorders in co-operation with the Ministry of Education.

**Non-profit**

Numerous non-profit associations representing consumer groups offer consumers and survivors support (individual and family), education and advocacy. Such associations as the BC Schizophrenia Society, the Anxiety Society of BC, and the FORCE Society for Kid's Mental Health Care are funded through provincial grants and fundraising.

### 4.2.3 Maples Adolescent Treatment Centre

The MATC is a designated provincial mental health facility pursuant to the provisions of the Mental Health Act of BC.[9] It opened its doors in 1969, and has served the entire province ever since. Ministry authority for the MATC was initially under the Ministry of Health and now is under the Ministry of Child and Family Development. The MACT, located in Burnaby, provides

[9] Description of the MATC, its programs and services is from the written documentation available at the centre.

residential (32 beds) and non-residential (16 intensive treatment spaces) to its target population. It consists of youth, between the ages of 12 and 17, with significant psychiatric and behavioural difficulties as well as those found not criminally responsible due to a mental disorder (NCRMD) or unfit to stand trial. MATC's mission is to assist communities in recognizing and developing their capacity to plan and take care of children and youth with mental health concerns, including serious mental illness, from across the Province of British Columbia. To accomplish its mission the MATC is working at two levels. The first one is by offering direct services to the youth, their caregivers and their home communities which translates into a variety of programs some residential and some non-residential. The second level consists in offering indirect services such as educational and awareness programs targeting caregivers and mental health practitioners as well as schoolteachers, administrators and social workers. A more complete description of the programs and services at the MATC can be found in the section pertaining to models of mental health care.

# 5 Analysis of Barriers to Care and Models of Service Delivery: Lessons from the Literature

Access to care for youth with severe mental illness is dependent on services available but these are not the only barriers. By paying a closer look to other barriers to care, we will be able to assess how successful the different models of care are at removing or overcoming these barriers and what strategies the province of British Columbia has put in place to reduce them. As we shift from an institutional-based service model, where barriers to care were often articulated in terms of medical or clinical expertise, it is important to refocus the attention to the barriers that are more significant in a community-based perspective. The first part in this section looks at barriers to care and the second part introduces different mental health models, community-based and institutional-based.

## 5.1 Barriers to Care

The WHO, in a document setting directions for caring for children and adolescents with mental disorders, identifies barriers to care as the reason such a large proportion of children and youth with mental disorders remain untreated (WHO, 2003, p. 9). The main barriers identified are lack of resources, stigma, lack of transportation, lack of ability to communicate effectively in the patient's native language, lack of public knowledge about mental disorders in children and adolescents. A recent Ontario study on the rural perspective on continuity of care differentiates between personal, systemic and environmental barriers. For the study, 30 parents were interviewed as well as 30 service providers. The findings are that the responsible factors include family, economic challenges, waiting times for care and school barriers.

### 5.1.1 Personal-level Barriers

**Stigma**

In the literature on mental illness, stigma is directly associated with access to care. Corrigan and Penn (1999, p.765) define stigma as "negative and erroneous attitudes about a group of people". They assert that the impact of stigma on the person's life can be as harmful as the

direct effects of the disease and that stigma leads to prejudice and discrimination. Just as ordinary citizens have negative stereotypes so do well-trained professionals from most mental health disciplines (Corrigan & Penn, 1999, p.766; WHO, 2003, p.10). Stigma delays or prevents access for many and, once the youth is "labelled", consumers feel that it remains (Boydell et al., 2004, p. 5). Families who have a child with a severe mental illness are not immune to stigma. Some have reported lowered-self esteem and strained relationships with other family members because of stigma. Corrigan and Penn (1999, p. 767) refer to this as "stigma-courtesy, being stigmatized because of association with someone with a severe mental illness". The authors report the findings of a survey reported in the bulletin of a schizophrenia association where 75% of family members believed stigma decreased their children's self-esteem, hindered their ability to make friends, and undermined their success in obtaining employment. Aboriginal groups in BC have identified stigma as a significant problem within small communities, and often associated with the lack of trust toward professionals (CYMHP, Revised 2004, Appendix B, p. 5)

**Family Factors**

In the rural Ontario study, families reported that lack of support from spouses, the needs of other children, as well as work responsibilities made it hard to get their ill child the medical attention he or she needed (Boydell, 2004, p. 7). In many families, parents did not agree on the need to seek formal help for their child. Getting childcare and juggling work schedules to get to mental health services or medical appointments are also important factors. The stress of dealing with family disruptions can be exacerbated by the lack of understanding professionals have of the families who have a youth with a severe mental illness. The Ministry of Health, in establishing best practices around family involvement and support, recognizes the need for ongoing training and sensitization to the effects of mental illness on families (Ministry of Health and Ministry Responsible for Seniors, undated).

**Economic Challenges**

Single parents, families living in rural areas and poor families are at a disadvantage when it comes to accessing care for a youth with severe mental disorders. The need to travel great distances to access care often entails having to take time off work, cost of gas, and wear and tear on the car, parking, meals and sometimes hotel accommodation (Boydell et al. 2004, p.7).

### 5.1.2 Systemic-level Barriers

**Lack of resources (financial, trained personnel and facilities)**

Uneven distribution of resources, declining enrolment in psychiatry training programs, and reduction in those working in community settings are some of the barriers to care. Chronic underfunding and ineffective use of funds both contribute to the situation (WHO, 2003, p.9). In rural communities: recruitment and retention of children's mental health specialists and shortage of specialized services means long waiting lists and out-of-town referrals. The lack of training of practitioners in dealing with child and youth mental illness means that families determined to have treatment or services for their youth often need to see a number of physicians to find the right one. They complain that many practitioners end the treatment after only a few visits. Because of this, families felt undervalued or ignored (Boydell & Pong, 2004, p.10).

**Lack of recognition of cultural diversity**

Studies have shown culturally diverse children to be under-represented in mental health institutions and over-represented in child welfare and juvenile justice settings and placements compared to non-minority youth, even when they are equally psychiatrically impaired (Pumariega, Winters & Huffine, 2003, p. 409). The WHO (2003, p. 11) states that a mental disorder can rarely be adequately diagnosed or treated without a common language and similar cultural references. The Child and Youth Mental Health provincial ethnocultural consultation confirms that more needs to be done to provide culturally sensitive clinical services (CYMHP, Revised 2004, Appendix, B, p. 6).

**Lack of Information**

The recognition of the complexities of mental life of children and adolescents is somewhat recent (WHO, 2003. p. 11). The general attitude was that children forgot and bounced back even after emotional painful experiences, such as losing a parent or being abused. Depression or other mental disorders were rarely diagnosed. Now that we recognize that children do have enduring mental health problems, the WHO (2003, p.11) cautions that more efforts have to be made to get objective information into the hands of parents and providers. There are few sources of unbiased information. For example, the pharmaceutical industry frequently conveys information about mental disorders. A very important gap in information is the lack of awareness

of the availability of mental health services (Boydell and al, 2004, p.6; CYMHP, 2004, Appendix B).

**Rural communities**

Rural communities often face geographic barriers as well as other specific barriers to care. Stigma can be greater in rural communities as privacy is not easy. There is also great difficulty in maintaining continuity of care because of gaps in service, lack of integration, and territoriality or turf wars (Boydell & Pong, 2004, p. 10). The strain facing rural families has profound effects on the adjustment and mental health of rural youth (Conger, Elder, Lorenz, Simons, & Whitbeck as cited in Cutrona, Alvorson & Russell, 1996, p.217) and the prevalence of mental disorders can be different from urban areas (2003 Adolescent Health Survey, McCreary Centre Society).

**Territoriality**

Federal, provincial and local policies interfere with consumers' ability to easily access services (Boydell & Pong, 2004, p. 10). The authors also report that service programs adhered to rigid policies regarding criteria for program acceptance, adding to families' frustration in not being able to access the already limited services.

**School barriers**

Parents feel the need for greater partnership between the mental health system and the school system, including the provision of counselling for mental health into the school system, especially at the secondary levels (Boydell & Pong, 2004, p. 10).

### 5.1.3 Environmental-level Barriers

Distance is a major environmental barrier as well as weather. Access to out-of-town services means travel cost, lost wages and the stress of travel and of being in unfamiliar locations when consulting (Boydell & Pong, 2004, p.17). Distance is also a barrier for service providers who can spend as much as half their time travelling to see clients.

Some of these barriers to care are addressed in the present youth mental health reform in the province, but more effort has to be directed at reducing or eliminating the ones that prevent family and community participation. In sections 7, the three levels of barriers are used to organize findings from the analysis of youth mental health needs and resources in the province.

## 5.2 Models of mental health care

This section presents models of care for people with mental illness. British Columbia follows some of these models. Not all of the models are designed specifically for the care of youth with severe mental illness, but they are chosen because they highlight essential aspects of care, whether it is at the community level or at the institutional level. By looking more closely at the principles behind the models, we can draw out the ways in which they reduce the barriers to care. The section looks at community-based and residential-based models.

### 5.2.1 Community-Based Models and Interventions

This section looks at three community-based models as well as some community-based interventions. The models are based on different theoretical frameworks but offer similar views on the organization of services and the development of resources for people with mental illness. The first model, the Community Resource Base model, applies to all consumers whereas the Systems of Care model targets children and youth. Following the descriptions of the models are different community-based interventions.

**Community Resource Base Model**

The Canadian Mental Health Association (CMHA) developed this model in 1993 to show that it takes more than clinical and medical services, either in the community or in the hospital, to meet a person's mental health needs.[10] It is the operationalization of the conceptual "Knowledge Resource Base" model of the CHMA that "highlights the legitimacy of generally overlooked sources of information about mental health and mental illness: not just medical/clinical, but also social science, experiential and customary and traditional perspectives."(Pape & Galipeault, 2002, p.10).

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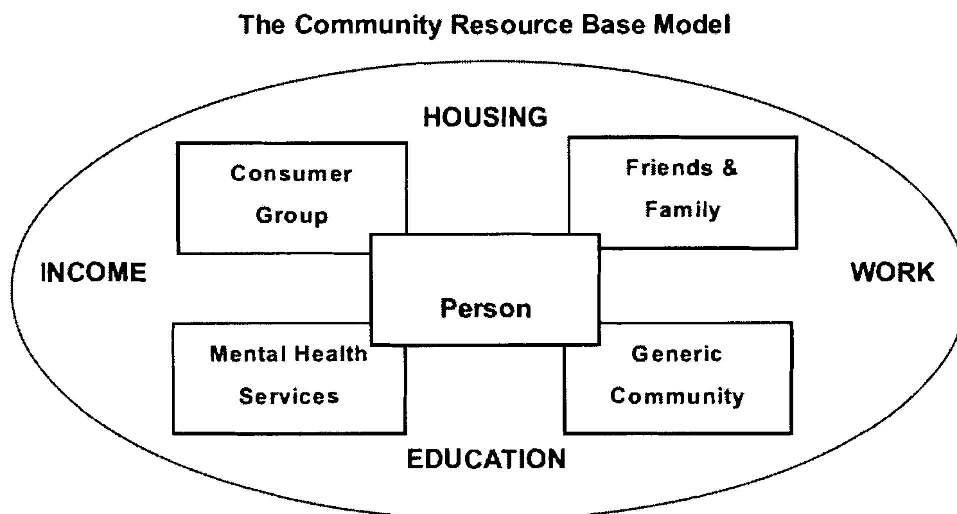
[10] Description of the CMHA Community Resource Model is from Pape & Galipeault (2004) and from the association website http://www.cmha.ca.

As illustrated in Figure 3, the Community Resource Base Model places the person in the middle. It is person-centred model as oppose to a system-centred model. In practical terms, it means that we are looking at the need of each individual through their own lens, their own perspective, to establish the range of resources the person needs to treat his or her mental disorder, to recover and to maintain an optimal level of mental health. Surrounding the person are the four basic categories of required resources: family and friends, generic community services and groups, mental health services, and consumer groups and organizations. In the large circle are income, education and housing, the "fundamental elements of citizenship" (Pape & Galipeault, 2002, p.10) to which access is essential.

*Figure 3. The Community Resource Model*




*Source: The Canadian Mental Heath Association*

In this model, the number one priority of families is their inclusion in the care team: family support is key to the individual's recovery. It is a participatory model because it shows who needs to be involved in planning and decision-making.

### Systems of Care Model

The systems of care philosophy was developed in the US by Stroul and Friedman (1986, as cited in Anderson, Wright, Kooreman, Mohr and Russell, 2003, p. 64) and is most applicable to children and youth with complex problems and who require services across agencies. Its purpose is to organize mental health and other youth services into coordinated, comprehensive service networks that can better respond to the complex needs of youth with severe mental disorders. The systems of care principles are:

1. Access to a comprehensive array of services;
2. Treatment individualized to the child's needs;
3. Treatment in the least restrictive environment possible (with full utilization of the resources of the family and the community);
4. Full participation of families as partners in services planning and delivery, interagency coordination;
5. The use of case management for services coordination;
6. No ejection or rejection from services due to lack of "treatability" or "cooperation" with interventions;
7. Early identification and intervention;
8. Smooth transition of youth into the adult services system;
9. Effective advocacy efforts;
10. Non-discriminating and culturally sensitive services (Pumariega et al., 2003, p. 404).

The authors stress that assessment and treatment within the systems of care model are designed to support "consumer families in having true access (quality and relevance, especially culturally)".

### Wraparound Model

A more family-centred approach to the systems of care principles, the wraparound model redefines the relationship of family to the care system (Pumariega et al., 2003, p. 404). The team around the youth is comprised of fewer than 50 percent professionals. This ensures a safe level of clinical expertise if a more restrictive type of intervention is needed, such as short-term hospitalization, while maintaining a majority of team members who have a strong emotional link to the youth. The wraparound model means that a crucial element for success in returning a

youth to mental health is a strong family advocacy movement in a community. This framework empowers consumer families as the team includes extended family, friends, neighbours and natural helpers in the community with the parent or older child as the team leader. The model aims for new roles and functions for professionals where they work in a more collaborative way and where their clinical expertise is valued but not the only expertise needed to make decisions about the care of the youth.

## Community-Based Interventions

### Shared Care

Based on a growing acknowledgement that primary care givers are already delivering significant amounts of mental health care shared care may be a possible solution to the shortage of specialized mental health care providers (The College of Family Physicians in Canada and the Canadian Psychiatric Association Collaborative Working Group {CPA/CFPC}, 2003). It involves collaboration between providers from different disciplines who share the responsibility for the care a person receives.

### Telepsychiatry

Telepsychiatry is the use of telehealth for psychiatric consultations. The provincial Health Services Authority defines telehealth as the "use of communications and information technology to deliver health and health care services, information and education where participants are separated". [11] This technology will help improve access by overcoming barriers of geography, transportation or socio-economic disparity. There are over 40 videoconferencing sites in the province.

### Multisystemic

This approach combines home-based, wraparound, cognitive-behavioural [12] interventions within a systemic approach meaning that interventions are guided by the needs of the youth in relationship to his family, his school and his community (Pumariega et al., 2003, p. 413). It is often used to treat youth with conduct disorder.

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[11] From the Provincial Health Authority website.

[12] Cognitive-behavioural therapy combines thought restructuring, self-monitoring, social skills training, problem solving, relaxation training, and self-management strategies (Pumariega et al. , 2003, p. 413)

These community-based models and interventions illustrate the different elements required to care for youth with mental illness. The Community Base Resource Model and the Systems of Care model can be seen more at the macro level from which the comprehensive care of the youth is organized. The community-based interventions are developed from similar conceptual frameworks. The Community Base Resource Model of the CHMA, sets the stage for a discussion around defining the community by putting non-health services at the same level of importance to the consumer than other services. It also reinforces an essential aspect of what consumers want, which is more than psychiatric services. They want work, housing, income and social connections. The Community Base Resource Model also makes families a key component of the care of the individual, even one who is adult. This comes from the realization that the continuity of care often depends on relatives. The systems of care model is the one chosen for the province of British Columbia to deliver care to children and youth with mental illness. In the literature produced for the ministry of Children and Family Development and for the ministry of Health, the third principle is often referred to (treatment should be done in the least restrictive environment). The Plan has many of the elements found in the systems of care model such as case management, early intervention and prevention, personalized care family involvement, etc. This model does address some of the barriers to care at the systemic level by suggesting a continuum of care (array of services and transitions), attention to cultural diversity, case management. The wraparound model, which is an adaptation of the systems of care model, looks to restore the balance in the mental health team by insuring a majority of community or family members on the team. As was suggested, it requires strong advocacy groups that usually need resources to do the job consistently well. The systems of care model also values families and their involvement at all stages of service planning and delivery. It also recognises the importance of addressing cultural diversity.

Some community-based interventions such as Shared Care and Telepsychiatry focus on mental health practitioners, and benefit rural and remote areas where qualified human resources are scarce. Finding new ways of offering medical services is important, as it does not appear that the number of youth psychiatrists will increase sufficiently to expect an acceptable ratio of specialist for the youth population in all regions of the province. The potential number of mental health practitioners as well as their level of expertise is important to consider in community-based strategies and models. It might be precarious to implement strategies that depend too much on the

medical and clinical expertise. Would a multisystemic intervention be possible in a remote area where environmental barriers mean that it would be difficult and costly to involve health care workers from different disciplines?

### 5.2.2 Residential based model

The Maples Adolescent Treatment Centre that serves the entire province is an example of a residential model. It offers different programs specific to the psychiatric diagnosis. The length of stays at the MATC varies between 28 days up to 3 months for most youth. In the past, stays could be much longer and in some residential facilities, this remains the case. At the MACT, length of stays were gradually reduced starting in the late 1980s as part of a reorganization of services due to deinstitutionalization, and it is at that time that the first community based program at the MACT was offered (Verlaan, 1991).

All services and programs at the MATC are based on attachment theory. According to Moretti et al. (1997, p. 640) attachment theory proposes that "experiences within the child-caregiver relationship are reflected in the development of "internal working models" or belief systems". An adolescent health survey conducted by the McCreary Centre Society (1998) has showed that connectedness is related to the concept of resilience[13] and that connectedness to family and school, and some individual characteristics, seem to promote resilience and to protect against risks during teenage years. Consistent with this theoretical framework is a multi-systemic approach, meaning that interventions are guided by the needs of the youth in relationship to his family, his school and his community. The staff at the MATC works together, across disciplines, to develop a 'Careplan' for the youth which includes input from psychiatry, psychology, social work, nursing, child care, education and vocational. The Careplan is the community tool that guides interventions. Everyone who is involved in a program at the facility leaves with a detailed Careplan. It is a portable document as it can be used by any community where the youth and her family chose to live and it has sufficient information to help anyone working with the youth to understand his or her needs and to plan interventions appropriately. Intake is done through child and youth coordinators at the local mental health centres or by physicians.

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[13] Resilience in mental health can be described as the quality that allows the individual or the community to function well despite negative odds. Two concepts are associated with resiliency: protective factors and risk factors (Pape & Galipeault, 2002, p. 13)

**Programs at MATC**

The following descriptions of programs are offered at MATC provides information that will be useful in looking at the admission data. The programs are designed for specific clienteles and, with this in mind; we will be able to draw out some patterns of usage of the services at MATC by region and gender. This is useful in understanding the resource need filled by MATC. The programs are staffed by psychiatric nurses and child and youth counsellors. All youth enrolled in a program, residential or non-residential, can attend school on the premises and have access to art and recreational facilities (gym, pool and evening programming). Each program is housed in a different building on the site of the MATC.

Response Program

The Response Program was expanded in the early 1990s as part of phase III of the MACT's decentralization initiative. Its clinical model emphasized support of community placements after a 30-day assessment period (Verlaan, 1991). The program today remains short term and can be accessed on a non-residential basis for Lower Mainland residents. A founding principle of this program is to maintain youth in their community of origin and the hope is to be able to implement similar non-residential programs in the community (Moretti et al 1997, p. 641).

Dala Program

The Dala Program is a treatment program for youth with thought, affect, or anxiety disorders. It has six residential treatment beds and a non-residential pilot project for some Lower Mainland residents. The program is primarily for voluntary admissions, stays are 90 days and a Careplan is completed for the youth and his caregivers in time for discharge.

Crossroads Care Program

The Crossroads Care Program offers a secure residential setting for a maximum of eight youth with conduct disorders. Admissions can be voluntary, involuntary, for youth 'Not Considered Responsible for Reasons of Mental Disorder' (NCRMD) and for youth unfit to stand trial. Youth admitted into Crossroads Care Program have severe conduct and psychiatric disorders and the daytime ratio of staff per youth is very high and, at times, is one on one.

Bifrost Program

The only exclusively non-residential program is the Bifrost Program which was implemented in the recent years. It is on a 3.5 months cycle, with three cycles a year. A total of 8

youth and their families can participate in a cycle. The program has three components: family therapy, a parenting group based on attachment theory and support for youth in their own everyday environment. Eight childcare counsellors work in teams of two and are assigned two youth per cycle.

**Services at MATC**

Outreach is a consultative service to communities once a youth is discharged with a care plan from a MATC program. The counsellors, called Careplan consultants, are assigned to the youth at the time of the discharge meeting and have the responsibility to interpret the Careplan. They are involved in integration meetings, case consultations and integrated case management. They remain involved with youth until they turn 18 years of age. The Careplan consultants are based at the MATC in Burnaby but travel to their assigned regions, anywhere in the province, on a per need basis. They are also responsible for respite admissions.

Other services at the MATC include Bridge, a transition program from the on-site secondary school to the community school and school liaison. The Burnaby School District operates the Maples Secondary School and the Ministry of Education has educational consultants at the school. Finally, vocational counsellors are available when needed.

In a provincial document identifying best practices for inpatient and outpatient services in the context of the province's mental health reform, the authors limit their recommendations when it comes to describing best practices in a residential inpatient setting, noting that because few residential services are available, "it is premature to describe a detailed best practices model for adolescent residential treatment." (Ministry of Health and Ministry Responsible for Seniors, 2002, p. 23). There seems to sufficient expertise in treating youth in residential facilities in the country and perhaps a wider survey of services might have informed best practices in this area. But the working group did make a few basic recommendations are: 1) adolescent inpatients be treated in a separate setting from adults; 2) adolescent units should be throughout the province, where population permits; 3) these units do not have to be in an acute-hospital but should have a more residential atmosphere, and; 4) that residential units should be part of a spectrum of care to be used in a least restrictive manner.

The apparent reluctance described above at identifying best practices in adolescent residential setting could also come from some degree of political and social unease. Residential treatment facilities always were surrounded by controversy partly because of mixed opinions about separating youth from their families (Hair, 2005, p. 552), stigma about mental illness, and the intrinsic nature of such facilities. Indeed, they are usually isolated and secure, and because they need to protect their residents, they tend not to attract attention to them. The MATC fits this description. However, controversy and lack of visibility are not sufficient to bring a shift from residential treatment to community-based treatment. Cost is an important factor (Moretti, Emmrys, Grizenko, Holland, Moore, Shamsie, and Hamilton, 1997; Berland, 2001) and according to some, lack of clinical evidence of their effectiveness (Moretti et al., 1997, p. 640; Wadell et al., 2005, p. 231). There are times though when a community-based setting cannot meet the needs of youth with severe mental illness. This is why the effectiveness of residential-based treatment needs to be assessed, and Hair (2005, p.552) suggests that this can be done by investigating what happens to residents after discharge. In a review of research in the past ten years on outcomes for children and adolescents after residential discharge treatment, Hair (2005, p. 552) reports that three factors contribute in maintaining gains after leaving: 1) family involvement before discharge 2) stability where youth is going after discharge and, 3) aftercare support. These findings help us understand that even after treatment in a residential setting, community and family matter. It shows that whether the treatment is community-based or residential-based it is essential to invest in developing community and family capacities.

One caution from the above discussion is the fact that decisions to reduce residential services without establishing strong community-based resources could harm the youth and families who already have limited access to care. The review of literature did not indicate youth and family preferences as to the type of care. Does trust in the residential institution influence a parent's perception of its efficiency (Dussault & Lapierre, 1973, p. 881)? How do they feel about community-based services where the level of expertise might be considered lower? Because options are limited and health care practitioners make referrals, it should not exclude youth and families from planning and prioritizing.

# 6 Youth Mental Health Needs and Provincial Resources

From the discussion below, we will be able to draw out some of the issues of delivering mental health care to youth in British Columbia. To understand the scope of the challenges facing the province in the development of services it is important to remember that the province of British Columbia is Canada's third largest province and covers a large area totalling 95 million hectares. The majority of its 4.1 million habitants are concentrated in the Lower Mainland. The population is comprised of at least 40 ethnic groups and more than 60 language groups.[14]

The 2003 Adolescent Health Survey (AHS), conducted by The McCreary Centre Society, is a population-based survey of the health status and risk behaviours of BC adolescents. It is the largest survey of its kind in Canada and provides valuable information on the health status of BC youth. The AHS was administered in over 1,500 classrooms by approximately 190 public health nursing staff during the spring of 2003. Over 30,000 BC students in grades 7 through 12 completed a questionnaire. The survey is an important tool in understanding the mental health needs of youth in the province. It offers a valuable youth perspective that seems to have been overlooked so far in the development of the Plan. It also helps link mental disorder prevalence rates with reported mental health status. Another useful aspect of this survey is the desegregation of the information by region and gender. This allows for comparison with the admission data from the MATC.

The report finds a small percentage of youth (8%) who experience serious emotional distress (Table 3) which concurs with similar surveys The McCreary Centre Society did in 1998 (7%) and 1992 (6%). These percentages are on the highest side of the range of estimated prevalence of severe mental disorders as reported in the literature. Distress is high among youth with a health condition or disability and with those who have been abused, according to the report. Girls (10%) are more likely to feel distressed than boys (6%) and older students are more

[14] Source: Tourism BC.

likely to experience distress. Girls are reporting more physical and sexual abuse than boys. Eighteen percent of girls reported being physically abused compared to 12% of boys, and 13% of girls reported being sexually abused compared to 2% of boys. The number of youth who have seriously considered suicide is slightly above the number of youth reporting serious emotional distress. Many factors, internal and external, contribute to youth feeling suicidal. This project does not look at these in any detail, but looks at suicide intent as an indication of severe emotional distress. An important finding is the percentage of girls who have considered suicide is nearly twice that of boys.

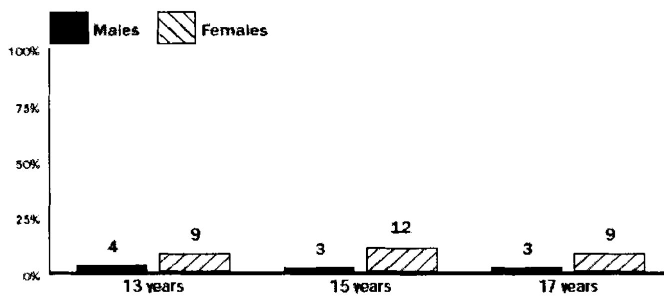
*Table 3. Percentage of youth surveyed (total 30,000) who reported feeling seriously emotionally distressed and seriously considering suicide, per region in BC, 2003.*

| | Seriously Emotionally Distressed | | | Seriously Considered Suicide | |
|---|---|---|---|---|---|
| | Male | Female | Total | Male | Female |
| Fraser | 6% | 10% | 8% | 11% | 21% |
| Vancouver Coastal | 6% | 11% | 8% | 10% | 19% |
| Vancouver Island | ---- | --- | 7% | 10% | 19% |
| North | --- | --- | 7% | 11% | 25% |
| Interior | 5% | 12% | 8% | 12% | 23% |

*Source: 2003 Adolescent Health Survey, The McCreary Centre Society.*

While the report finds that twice as many girls attempt suicide than boys, boys are more likely to die of suicide than girls. Figure 4 shows the percentage of youth who reported attempted suicides in 2002. Finally, location matters. The 2003 AHS found that the percentage of youth who considered suicide is highest in the Northwest and in the Kootenays.

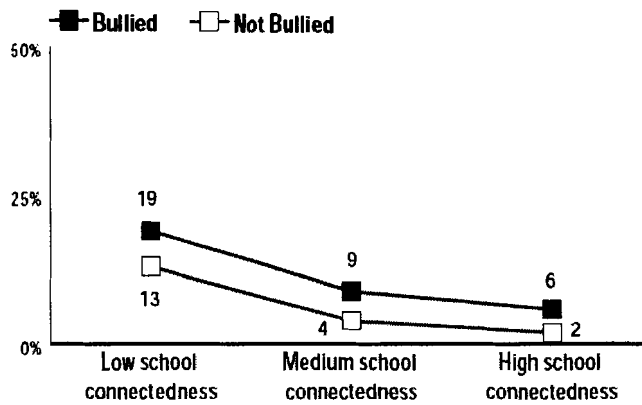
*Figure 4. Percentage of youth surveyed (total 30,000) who reported attempted suicide in 2002, by gender and age, in British Columbia*




*Source: 2003 Adolescent Health Survey, The McCreary Centre Society.*

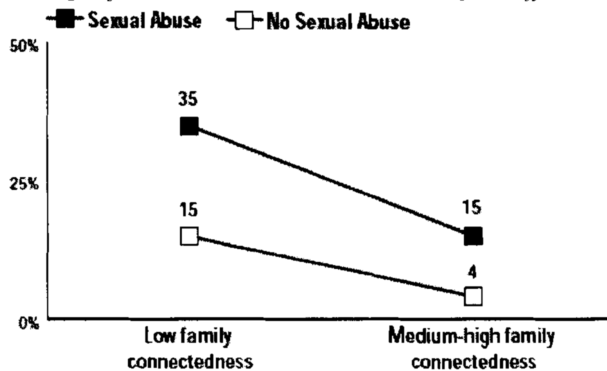
The 2003 AHS survey also looked at connectedness. As was previously discussed, attachment or connectedness, are important factors in the development of a healthy youth. Youth with caring relationships at home, at school and in their daily lives, have a better chance of being well adjusted, even if they have a mental disorder. Such connections are part of resilience building. The shift from institutional-based care to community-based care is in part motivated by the desire to preserve or strengthen these caring relationships. The 2003 ADH survey confirms that youth who feel connected and safe at home, at school and in the community have better health, are less likely to engage in risky behaviours, and have a higher educational aspirations (p.28). Also of interest, family connectedness decreases with age: 32% of 13-year old students are highly connected to their families, compared to 25% at age 15, and 22% at age 17. Figures 5 and 6, show respectively that for any given level of connectedness, those who have been bullied or subjected to sexual abuse will more likely attempt suicide or experience emotional distress. Bullying and sexual abuse are thus additional risk factors that reduce total connectedness and increase likelihood of suicide attempts and emotional distress.

*Figure 5. Percentage of Youth Who Attempted Suicide for Different Levels of Connectedness*




*Source: 2003 Adolescent Health Survey, The McCreary Centre Society.*

*Figure 6. Percentage of Youth With Emotional Distress for Different Levels of Connectedness*




*Source: 2003 Adolescent Health Survey, The McCreary Centre Society*

## MATC Admission Data

Table 4 presents data obtained from the MATC admission data for 2003-2004.[15] The data from MATC was for two years but only one year is used for this project (see Appendix B for 2004-2005 admission data). Total number of admissions is similar for both years. Some programs are new, others are terminated which accounts for some of the changes. The major difference has been a decrease in 2004-2005, of 50% in the number of youth from the Interior. In 2003-2004, 30 youth were admitted at the MATC compared to only 9 youth in 2004-2005. For the purpose of this analysis only the data for the year 2003-2004 are used as they are for the same year as the 2003 Adolescent Health Survey.

[15] The year if from April 1st to March 31st.

For the year 2003-2004, the total number of admissions at MATC is 252, of which 158 are males (64 %) and 94 are females (37%). Admissions to a program cancelled the following year are not included (8 youth) as well as entries for which the region was unknown, bringing the total to 14 entries. The admissions to the Outreach and Bridges services are also not included in the admission data because they are not new admissions to the MATC, but rather an internal transfer to an aftercare program. The majority of youth admitted to the MATC are transferred to Outreach at the time of discharge and remain on the caseload until they reach 18 years of age. In 2003-2004, 155 youth were assigned to the caseloads of Outreach staff. Table 4 looks at the total number of admissions at the MATC for all programs, residential and community. The Bifrost program is only non-residential and has a total capacity for 24 youth, 8 admissions per cycle and 3 cycles per year (one youth might have dropped out of the program and was replaced by another one which could explain the total of 25 admissions). The majority of youth, 68%, comes from the Fraser region. This matches the youth population distribution between the Fraser region (65%) and the Vancouver Coastal region (35%). The other non-residential program is Response, which is a 28-day program. The admissions from the Fraser region are only slightly higher than the population between the Fraser region and the Vancouver Coastal region. These two non-residential programs for Lower Mainland youth and families account for 32.5% of total admissions to the MATC. Referrals to non-residential programs represent 43% of admissions to MACT from the Fraser region and 41% of admissions from Vancouver Coastal.

*Table 4. Total admissions at MATC,in all prgrams, residential and non-residential, 2003-2004.*

**All Regions and all programs, Crosstabulation, 2003-2004**

| | | | Program | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | | | BF | CCP | DALA | RPN | RR | |
| Region | Fraser | Count | 17 | 13 | 6 | 40 | 56 | 132 |
| | | % within Region | 12.9% | 9.8% | 4.5% | 30.3% | 42.4% | 100.0% |
| | | % within Program | 68.0% | 44.8% | 26.1% | 70.2% | 47.5% | 52.4% |
| | | % of Total | 6.7% | 5.2% | 2.4% | 15.9% | 22.2% | 52.4% |
| | Vancouver Coastal | Count | 8 | 3 | 9 | 17 | 23 | 60 |
| | | % within Region | 13.3% | 5.0% | 15.0% | 28.3% | 38.3% | 100.0% |
| | | % within Program | 32.0% | 10.3% | 39.1% | 29.8% | 19.5% | 23.8% |
| | | % of Total | 3.2% | 1.2% | 3.6% | 6.7% | 9.1% | 23.8% |
| | Vancouver Island | Count | 0 | 5 | 0 | 0 | 3 | 8 |
| | | % within Region | .0% | 62.5% | .0% | .0% | 37.5% | 100.0% |
| | | % within Program | .0% | 17.2% | .0% | .0% | 2.5% | 3.2% |
| | | % of Total | .0% | 2.0% | .0% | .0% | 1.2% | 3.2% |
| | North | Count | 0 | 2 | 2 | 0 | 18 | 22 |
| | | % within Region | .0% | 9.1% | 9.1% | .0% | 81.8% | 100.0% |
| | | % within Program | .0% | 6.9% | 8.7% | .0% | 15.3% | 8.7% |
| | | % of Total | .0% | .8% | .8% | .0% | 7.1% | 8.7% |
| | Interior | Count | 0 | 6 | 6 | 0 | 18 | 30 |
| | | % within Region | .0% | 20.0% | 20.0% | .0% | 60.0% | 100.0% |
| | | % within Program | .0% | 20.7% | 26.1% | .0% | 15.3% | 11.9% |
| | | % of Total | .0% | 2.4% | 2.4% | .0% | 7.1% | 11.9% |
| Total | | Count | 25 | 29 | 23 | 57 | 118 | 252 |
| | | % within Region | 9.9% | 11.5% | 9.1% | 22.6% | 46.8% | 100.0% |
| | | % within Program | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | | % of Total | 9.9% | 11.5% | 9.1% | 22.6% | 46.8% | 100.0% |

*Note: BF: Bifrost, non-residential; CCP;Crossroads Care Program, residential; Dala, residential; RPN: Response non-residential; RR: Response Residential.*

Because one third of admissions to the MATC are for non-residential programs, it is useful to look at the admissions to residential programs only, in order to establish patterns of usage by program and by region. Table 5 shows admissions from the five administrative regions to the three residential programs, Crossroads Care Program, Dala and Response. The later, Response is by far the program that has the highest number of admissions, 69% of the total for residential programs. This is not surprising as it is a 28-day program whereas Crossroads Care Program and Dala can have youth stay as long as 3 months. Close to half of the youth admitted to all three programs come from the Fraser region (44%). If we refer back to Table 2, we see that the number of youth from the Fraser region, as a percentage of total youth in the province, is 36%. Total admissions from Vancouver Coastal (20%) match the number of youth from the area as a percentage of all youth in the province, as well as from the Interior at 18%. The North where youth make up 9% of total youth population is overrepresented at 13%. The biggest difference is from the Vancouver Island region where youth make up 17% of total provincial youth and only 5% of the total admissions at the MATC. We will see later, when we look at the resources

available in each region, that Vancouver Island region has a large facility for youth with mental disorders which could explain the low admission rate in some programs.

These observations are based on the total of admissions to the MACT by region but we should note that these percentages change when we look at individual programs. The first observation is that admissions to Crossroads Care Program are much more reflective of the youth population dispersion by region. This can be explained by the fact that the program is unique in the province, because it offers a secure environment, it is very specialized, and operates with a high staff and youth ratio, sometimes one on one. The program offers treatment and assessment for youth with conduct disorders and, although most admissions are voluntary, some youth are admitted to the program because they are mentally unfit to stand trial or found not criminally responsible due to a mental disorder. Their care requires a high level of skills from the youth workers, psychiatry nurses, teachers and other personnel at the facility.

Dala offers a residential program for youth with severe anxiety disorders such as schizophrenia, or disorders such as anorexia or major depression. Dala also offers a secure environment and highly skilled staff. The major observation is the fact that there are no referrals to the program from the Vancouver Island area. As previously mentioned, this could be attributed to the large facility for youth in Victoria. Caution should also be used in looking at the data for this program and Crossroads Care program because they admit small numbers of youth every year. The table showing admissions for 2004-2005 in Appendix B shows similar results for the Dala program but very different one for Crossroads Care program where the admissions from the Interior dropped. The total number of admissions to this program went from 29 youth in 2003-2004 to 19 in 2004-2005. The length of stays could probably explain this large difference.

*Table 5. Admissions at MATC by region and residential program, 2003-2004.*

**Region and Residential Programs Crosstabulation 2003-2004**

| | | | Program | | | Total |
|---|---|---|---|---|---|---|
| | | | CCP | DALA | RR | |
| Region | Fraser | Count | 13 | 6 | 56 | 75 |
| | | % within Region | 17.3% | 8.0% | 74.7% | 100.0% |
| | | % within Program | 44.8% | 26.1% | 47.5% | 44.1% |
| | | % of Total | 7.6% | 3.5% | 32.9% | 44.1% |
| | Vancouver Coastal | Count | 3 | 9 | 23 | 35 |
| | | % within Region | 8.6% | 25.7% | 65.7% | 100.0% |
| | | % within Program | 10.3% | 39.1% | 19.5% | 20.6% |
| | | % of Total | 1.8% | 5.3% | 13.5% | 20.6% |
| | Vancouver Island | Count | 5 | 0 | 3 | 8 |
| | | % within Region | 62.5% | .0% | 37.5% | 100.0% |
| | | % within Program | 17.2% | .0% | 2.5% | 4.7% |
| | | % of Total | 2.9% | .0% | 1.8% | 4.7% |
| | North | Count | 2 | 2 | 18 | 22 |
| | | % within Region | 9.1% | 9.1% | 81.8% | 100.0% |
| | | % within Program | 6.9% | 8.7% | 15.3% | 12.9% |
| | | % of Total | 1.2% | 1.2% | 10.6% | 12.9% |
| | Interior | Count | 6 | 6 | 18 | 30 |
| | | % within Region | 20.0% | 20.0% | 60.0% | 100.0% |
| | | % within Program | 20.7% | 26.1% | 15.3% | 17.6% |
| | | % of Total | 3.5% | 3.5% | 10.6% | 17.6% |
| Total | | Count | 29 | 23 | 118 | 170 |
| | | % within Region | 17.1% | 13.5% | 69.4% | 100.0% |
| | | % within Program | 100.0% | 100.0% | 100.0% | 100.0% |
| | | % of Total | 17.1% | 13.5% | 69.4% | 100.0% |

*Note: CCP;Crossroads Care Program, residential; Dala, residential; RR: Response Residential.*

Table 6 looks at the admissions to the non-residential programs at MATC. The referrals from the Fraser region are twice that of Vancouver Coastal. It is in keeping with the ratio of youth between to two regions. The same ratio is found in the admissions in the residential programs. Although it is difficult to draw any conclusion from this observation, it shows that all programs at the MATC are used to capacity, even when more services are available in a region such Vancouver Coastal.

*Table 6. Total admissions in non-residential programs at MATC by region, 2003-2004*

**Region and Residential Programs, Crosstabulation 2003-2004**

| | | | Program | | |
|---|---|---|---|---|---|
| | | | BF | RPN | Total |
| Region | Fraser | Count | 17 | 40 | 57 |
| | | % within Region | 29.8% | 70.2% | 100.0% |
| | | % within Program | 68.0% | 70.2% | 69.5% |
| | | % of Total | 20.7% | 48.8% | 69.5% |
| | Vancouver Coastal | Count | 8 | 17 | 25 |
| | | % within Region | 32.0% | 68.0% | 100.0% |
| | | % within Program | 32.0% | 29.8% | 30.5% |
| | | % of Total | 9.8% | 20.7% | 30.5% |
| Total | | Count | 25 | 57 | 82 |
| | | % within Region | 30.5% | 69.5% | 100.0% |
| | | % within Program | 100.0% | 100.0% | 100.0% |
| | | % of Total | 30.5% | 69.5% | 100.0% |

*Note: BF Bifros, non-residential; RPN Response, non-residential. The referrals are from only two regions because the youth has to live close to the MATC to be admitted in the non-residential programs. .*

The data obtained from the MATC included gender and as more attention is paid to gender differences in mental health, it is useful to look at possible patterns in the use of the services at the MATC. The report on mental illnesses in Canada, suggests that the higher rates of depression for women begin in the teen years, earlier than for men. Depression in young women may result from a combination of biological, psychological and social factors. During high school, expectations regarding gender and social roles, such as the increased focus on body image and sexuality, can contribute to the development of depression. Changes in hormones may also play a role and women are more likely than men to have experienced trauma such as sexual abuse in childhood and rape in adulthood.

As previously mentioned in the description of the target population, female youth represent 49% of the youth population in the province. The admission data shows that they represent an average of 37% of youth in all programs at MATC. Only for Dala do they make up half of the youth admitted at 52%. In Table 7, we look at the admissions by region and gender. Only from the North and the Interior do we see the population composition reflected with equal ratios between females and males. Admissions by gender and programs are in Appendix C.

*Table 7. Admissions by region and gender for all programs at MATC, 2003-2004.*

**Region and Gender for All Programs Crosstabulation 2003-2004**

| | | | Gender | | |
|---|---|---|---|---|---|
| | | | F | M | Total |
| Region | Fraser | Count | 46 | 86 | 132 |
| | | % within Region | 34.8% | 65.2% | 100.0% |
| | | % within Gender | 48.9% | 54.4% | 52.4% |
| | | % of Total | 18.3% | 34.1% | 52.4% |
| | Vancouver Coastal | Count | 20 | 40 | 60 |
| | | % within Region | 33.3% | 66.7% | 100.0% |
| | | % within Gender | 21.3% | 25.3% | 23.8% |
| | | % of Total | 7.9% | 15.9% | 23.8% |
| | Vancouver Island | Count | 3 | 5 | 8 |
| | | % within Region | 37.5% | 62.5% | 100.0% |
| | | % within Gender | 3.2% | 3.2% | 3.2% |
| | | % of Total | 1.2% | 2.0% | 3.2% |
| | North | Count | 11 | 11 | 22 |
| | | % within Region | 50.0% | 50.0% | 100.0% |
| | | % within Gender | 11.7% | 7.0% | 8.7% |
| | | % of Total | 4.4% | 4.4% | 8.7% |
| | Interior | Count | 14 | 16 | 30 |
| | | % within Region | 46.7% | 53.3% | 100.0% |
| | | % within Gender | 14.9% | 10.1% | 11.9% |
| | | % of Total | 5.6% | 6.3% | 11.9% |
| Total | | Count | 94 | 158 | 252 |
| | | % within Region | 37.3% | 62.7% | 100.0% |
| | | % within Gender | 100.0% | 100.0% | 100.0% |
| | | % of Total | 37.3% | 62.7% | 100.0% |

*Note: In row Total, total of % within gender is the same as total for region. It is an average.*

## Acute care adolescent psychiatric beds per health region

As previously mentioned, the Ministry of Health has 101 inpatient beds for children and youth with mental disorders, located in hospitals across the province. A survey of those hospitals establishes the approximate number of inpatient beds for adolescents to be half of the total, around 50, which represents ten non-emergency beds for short stays in each Health Authority except for Vancouver Coastal that has more. These beds are located in general hospitals, Prince George Regional Hospital (six beds), Kelowna General Hospital (eight beds), Surrey Memorial Hospital (ten beds) and Vancouver General (ten beds). Vancouver and Victoria have designated facilities for children, BC's Children's Hospital and Queen Alexandra Centre for Children's Health. It is important to note that admission criteria vary from one facility to the other and that a primary diagnosis of substance abuse or conduct disorder, for example, might be referred elsewhere.

### Number of psychiatrists in BC

A search on the website directory of the College of Physicians and Surgeons of BC comes up with 666 physicians who are specialized in psychiatry. It is not possible to establish how many are specialized in adolescent psychiatry but literature suggests that they are very few.

### Primary Care Physicians

The shortage of adolescent psychiatrists means that families need to rely on family physicians for assessment and referral and, at times, for treatment. As noted above, mental health care policies for youth typically overlook the vital role of primary care physicians in the care of youth with mental illness. Many physicians work in isolation from mental health workers who are often the ones who are familiar with support and services.

# 7 Analysis and lessons learned from the models and BC situation.

In this section, we discuss the findings regarding the needs of youth with severe mental disorders in the province and the resources available to them. We link these observations to the literature and propose barrier-reducing strategies from a community perspective that help identify policy options. The focus of this analysis is on the broader resources that communities need to care for these youth.

The first observation from the 2003 ADH survey and from the MATC is that the mental health needs of youth with severe disorders cannot be met with the current resources, at any level of the health care continuum. The MATC is the only specialized resource in the province and, despite shorter stays and innovative community-based programs, it cannot respond to the needs of all. There are not enough acute care resources at just over 50 adolescent psychiatric beds. Primary care practitioners, who have been overlooked in the mental health reform (Kates & al., 1997 as cited in ANMH, 2001, p. 32), are unable to meet the demand because they are serving large populations and large geographic areas. Most of the time, they are not equipped to effectively treat people with mental illness, using current concepts of diagnosis and treatment (Waddell et al. 2005, p. 231; WHO, 2003, p.15). The pressures on physicians to treat mental disorders will not diminish. In British Columbia, the use of physicians' mental health services (GPs and psychiatrists), over a five year period, had increased faster than use of physician services for other health problems (Hamdi & Bigelow, 1998; Lin & Goering, 1998 as cited in Goering, Wasylenki, & Durbin, 2000 p. 350).

The number of youth who do not have access to care in the different health authorities are high enough to have new specialized facilities such as the MATC operating outside the Lower Mainland and Capital region. There are many difficulties, cost being only one of them. According to Wasylenki et al. (2000, p.180) quality inpatient tertiary care requires a critical mass of

providers and patients which is most of the time not feasible in non-urban areas. It would be difficult to staff such a facility with highly specialized inter-professional teams, 24-hour nursing coverage and links to outreach teams. Finally, this type of setting requires high staff expertise and access to training and research for high clinical standards of practice. Wadell et al. (2005, p. 228) do not feel that investing more in specialized treatment services is the approach to take because the degree of unmet needs is so high that such facilities would not have a significant impact. In addition, when community resources and supports are increased, there is "no need to tie tertiary care to particular setting or time frame" (Wasylenki et al., 2000, p. 180). According to these authors, with the right level of expertise this level of care can be achieved anywhere. This view might offer hope for a less restrictive treatment setting for youth, as well as do away with environmental barriers and some systemic one, but Waddell et al. (2005, p. 231) feel that "training and recruiting more specialized practitioners or expand[ing] treatment services without reorganization [is] not the way to go."

Finally, an important fact that cannot be underestimated is that the need for more residential facilities is a top issue for staff at the Ministry of Children and Family Development and at the Ministry of Health (CYMHP, revised 2004, Appendix B, p. 13). Their staff are doing front line work and deal with the increased complexities of working relationships with different agencies and different levels of government (Goodwin, 1997, p. 139). In an institutional setting, it is relatively easy to coordinate services and staff. How do youth, their families and the different community stakeholders feel about institutional-based resources? Do they wish, like mental health workers, for more residential facilities? Is there a sense of safety and of something being done, perhaps "curing" the youth? But in a multidisciplinary context such as an institution, the medical model rules, and dismisses people's subjective experiences (Baily, 2004, p. 171). Boydell & Pong (2004, p.10) reported the same observation in a community-based setting. According to Baily (2004, p.170) community services are still delivered from an institutional philosophy so "distortions found in institutions remain or recur within the organization of in the community ". Therefore, the shift from institutional to community is not only a shift in resources and strategies but also a shift in discourse with user-oriented values and needs are the underpinnings (Baily, 2004, p. 173). Changing organizational cultures takes time, resources and openness.

The MATC data and the 2003AHS, both show that location and gender matter. Although it is beyond the scope of this study to suggest clinical services, the percentage of girls admitted to the MATC and the proportion of girls who have reported serious emotional distress and suicide ideas, raises the question as to the type of intervention they benefit from. Why is the North region of the province the only one that refers (or succeeds in having admitted) girls in the same proportion as boys? It is important to reinstate that one size does not fit all and that sensitivity to the needs of different groups includes such variables. The low admission of girls in some of the MATC raises some questions, as do the regional admission patterns.

Another observation derived from the previous section and from the literature review is the lack of definition of the community (Labonté, 1995, p. 177) and assumptions that community-based care is better. The 2003 AHS shows that youth with severe emotional distress or seriously considering suicide, do not have strong attachment or connectedness with their families and schools. The study also shows that, in general, as youth age, family connectedness decreases. This can have an important impact on the type of capacity building programs or family maintenance programs implemented in the community. The Bifrost program at the MATC, uses a multisystemic approach where as part of one strategy, parents take part in parent management training based on attachment. Moretti et al. (1997, p. 638) write that this type of intervention is more likely to produce improvement in younger children, and research suggests that combining parent management with other interventions raises the efficacy of these programs with families. Hair (2005) has shown that residential treatment outcomes are more positive when a youth goes back to a supportive environment with family involvement and after care support. Is the supportive environment the school, friends of the family and friends of the youth, church, neighbours and coach? Wolkow (2001, p. 489) recognizes that a warm cohesive family is a valuable protective factor but wonders about community support in the form of caring interactions between adults and children. He feels that this has received the least attention in terms of critical analysis and that there is no proof of a causal relationship between social support and resiliency. Wolkow (2001, p. 490) also points out that most research has focused on family variables. Finally, he suggests that the individuals who identify a person who made a difference in their lives have survived and those who cannot identify such a person have not survived.[16]

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[16] The term survivor is sometimes used instead of consumer. In this situation, the authors imply a subjective level of well-being has been achieved.

The diagram showing the Child and Youth Mental Health Network (Figure 2) reinforces the monolithic view of the community. Does community include generic groups and consumer groups or does it, as the CHMA Resource Base model suggests, have these in separate compartments? What role do these community components play and in what way can they be helped in developing skills and capacity to care for the youth with mental disorders? The number of agencies and ministries involved in the network show the potential difficulties in moving forward. It is also hard to isolate where the youth and his or her family are. Perhaps they are in the middle, because the Plan has been developed for them, but it is unclear. The makeup of this network raises many questions. Are the stakeholders, gathered around the three sectors in the middle, the Plan, research and database, there to advise and to participate in the development of those sectors? If that is the case, should youth and families not be there? Why are family physicians in the middle but not included with the stakeholders? They are an essential part of mental health delivery, in both settings, community-based and institutional-based (Advisory Network on Mental Health, 2001, p. 32; Glied & Evans Cuellar, 2003, p.41; Hair, 2005, p. 552). As we have seen in the key areas of the Plan, the community as a place of service and of support for youth with mental health disorders is a major focus. It is lost in this network of ministries and agencies. The same can be said of consumer groups. Aboriginal representatives are at the table but not cultural groups. In the MCFD's "strategic shifts" document, we read, "In the past, government has tried to build large, standardized, bureaucratic responses to challenges that exist at the individual and community level" (CYMHP, Revised 2004, Appendix D, p.1). It appears that this is what is happening with this network. Territoriality is as an important barrier to care as well as lack of information and lack of sensitivity to cultural diversity, as we see later. Removing, or at least reducing these barriers starts in the planning stages where who is at the table matters for the development of resources.

Fragmentation among jurisdictions, sectors, and disciplines which Waddell et al. (2005, p.231) identify is a long-standing problem in children's mental health. Several federal and provincial government ministries and agencies deliver programs and services, with little coordination among them. According to these authors "public health, primary care, acute care, special education, child protection and youth justice may all be involved. Adding to the fragmentation many practitioners function within disciplinary "silos" including psychology, social work, nursing and psychiatry" (Waddell et al. 2005, p. 231). This does not only apply to public services but also to the not-for-profit sector which is now offering more direct services. Not all consumers groups are working from the same framework and with the same values. The

fragmentation of services is an important barrier to care and, whether the care is a residential setting or a community setting, the lack of continuity jeopardizes the treatment as well as the recovery process.

Goodwin (1997, p. 118) feels that many assumptions are made about the community, starting with the assumption that because service is in the community it will be better. There is also the "social and cultural assumption about the family: female informal carers suffered as a result of lack of development of adequate services" (Goodwin, 1997, p. 146). He goes on to say that very little thought was given by government to the increased burden put on families with deinstitutionalization. Families who have limited abilities in dealing with the health care system and practitioners, who are involved with the welfare system or who cannot have cooperation from the school are facing even more challenges. Families living in rural areas, lone parent families, families living below the poverty line are also at a disadvantage. Is this where advocacy, one of the systems of care model, has a role to play?

The "closer to home"approach to mental health services for youth with severe mental illness needs to be looked at from the point of view of the youth, his or her family and the community. More needs to be done to establish with consumers what they would prioritize in the present social and economic environment. To do so, they need to be given a strong informed voice to speak on the challenges identified in this section.

To sum up, the challenges are the lack of residential facilities, the lack of trained health practitioners, the lack of resources for community-based tertiary care, the difficulty in shifting the discourse and practice from a bureaucratic, institutional and medical perspective to a community one, and fragmentation. Dominating these challenges is the lack of inclusion of youth, families and communities in the planning, delivery and outcome evaluation. The assumptions about community-based care as being better than residential-based care might come from an urban perspective and, as we have seen location and gender matter. The discussion on attachment and connectedness highlight the critical importance of family, in some situations and for some age groups more than for others, and leaves us with more questions than answers. By focusing on a youth, family and community perspective to discuss the above-mentioned challenges, strategies to reduce barriers to care and to increase resources can be tailored to meet the specific needs of consumers, in their specific region. The provincial government is acting on many of these,

training physicians, recruiting mental health workers, creating mechanisms to reinforce working partnerships, etc., but, in order for community-based care to be sustainable more strategies need to be framed from a community (youth, families and community) perspective. At the same time, the government would gain more understanding of diversity of communities and needs. These strategies do not require great financial investment, but can have great yield in the form of community involvement and ownership through empowerment.

The table below links the challenges and the gaps in resources for youth from a community (includes youth and families) perspective to the previously identified barriers to care. From these we will draw our policy options.

*Table 8. Community Perspectives on Strategies to Reduce Barriers to Care*

| Level | Barriers to Care | Community Perspective of Strategies to Reduce Barriers |
|---|---|---|
| Personal-level | Stigma<br>Family Factors<br>Economic Challenges | Recognition of burden for the family<br>Information regarding mental health<br>Recognition of gender differences |
| Systemic-level | Lack of resources (training, facilities, funding)<br>Territoriality<br>Lack of information<br>Rural communities<br>Schools | More resources<br>More information about available resources<br>Involvement of consumers and families<br>Recognition of the limitations of the medical model<br>Increased understanding of capacity and willingness of community stakeholders<br>Transition support between levels of care (residential to community, youth to adult)<br>Less confusion re accessing services and programs<br>Better coordination between consumers, primary care and mental health<br>Enabling not-for profit sector and public sector to work in collaboration |
| Environmental level | Geographic barriers | Recognition of regional differences<br>Emphasis on equal access to resources |

# 8 Policy Options

The child and youth mental health reform is underway in the province of British Columbia. A lot of work was put into developing the Plan such as extensive research and consultation done by the Mental Health Evaluation and Community Consultation Unit at the University of British Columbia, but the present study has identified important gaps in the design and implementation. The Plan has a strong community-building component but "while specific funds have not been assigned to buildings partnerships, it is a critical element of success of the implementation of the Plan" (CYMHP, revised 2004, p. 32). Family involvement and community participation are essential in ensuring that the resources needed by the families and the youth are developed. The management perspective dominates the agenda leaving little space for youth and their families who are the consumers. The Plan excludes youth and families as well as primary care physicians from the decision-making process. The Plan focuses on capacity building, but to use limited resources effectively, its operationalization and implementation requires a youth, family and community perspective. Assumptions about what youth, families and communities want and have need to be explored with all partners. Limited fiscal and human resources are not a reason to exclude consumers who might demand more, but on the contrary, they can help shape the direction of more sustainable policy options.

The following policy options do not focus on the quality of care but on the different types of resources, again interpreted broadly, needed to care for youth with severe mental illness. As we have established these resources encompass both mental health services and also families and friends, consumer groups and community groups. These options focus on a community perspective to bring a better balance with present provincial initiatives that focus on an institutional perspective.

## 8.1 Development and implementation of a child and youth mental health provincial communication strategy

Stigma, lack of information, limited resources and multiple jurisdictions are all barriers that could be greatly reduced with transparent and clear messages and with a consolidation of information. It is important to target health care professionals and other practitioners, but it is just as important to target families, friends, teachers, prospective employers, and other community members. A strong communication strategy would build support for the reform and reduce stigma (Berland, 2001). The communication strategy would include the following: 1) Information about mental illness and youth 2) information on all programs and services across jurisdictions and sectors; 3) roles and responsibilities of the different stakeholders; 4) child and youth mental health reform priorities; 5) the process to file a complaint.

Stigma is the major barrier to accessing care. With this in mind, the Plan has included an information strategy about mental illness and youth but does not expand on its focus. This strategy needs to educate the public about mental disorders, their incidence and the burden facing youth and families dealing with mental illness. It also needs to educate health care practitioners about youth mental illness and the difficulties facing their families in finding out about services and programs, in accessing them in a timely manner and in obtaining follow-up care. Finally, youth and families often do not feel heard by health care practitioners and they feel that their experience is undervalued. This is an important aspect of the information that needs to be transmitted to health care practitioners. It has the potential to improve greatly the care of the youth by improving the collaborative relationship between professionals and consumers. Families would be less hesitant to request assistance for their youth knowing that their concerns are taken seriously. Earlier intervention can mean a faster diagnosis, better treatment that is less intrusive and disruptive. This meets the goals of community-based care.

Knowledge is an important resource for youth and families in accessing care. Community members, family and mental health workers all reported not being able to find out where the services are. All referrals to acute care treatment and to residential care are done through mental health workers or physicians, which seems to free respective ministries from making the information available to the large public. The different government stakeholders value new technologies for the clinical/medical aspect of interventions in mental health (telepsychiatry, database) but also need to invest in information sharing, education and increasing consumer's ability to make decisions. This component of a communication strategy has the potential to bring

together all the stakeholders in a basic exercise of sharing and consolidating information geared towards consumers needs.

Consumers, families and communities need to understand better the roles and responsibilities of the different stakeholders. What can the school do and not do, who refers to a specialist, who decides what type of treatment is required and when hospitalization is required? This information is essential for youth and families to better utilize the resources available to them. In the MCFD "strategic shifts" document the first key item is open, accountable transparent relationships. This can be achieved in part by informing consumers about ministry priorities and by making the complaint process clear and manageable.

## 8.2 Reinstate the external advisory committee for child and youth mental health

In the community-based models of care, families and mental health consumers need to be involved not only in direct care but also in the planning stages and in the development of services. This is an essential component of the success of caring for youth with severe mental disorders in their own communities. The Child and Youth Mental Health Network shows clearly that youth and families do not have the voice that they need. Integrating them at the table is essential but the concerns remain about their ability to participate fully. The Network has an overwhelming majority of representatives from government ministries and departments, and it is unrealistic to expect the representatives from youth, families and communities to have the ability to involve themselves in all areas of mental health care. This is the reason why an external advisory committee is needed. It acts as a safety valve making sure that the needs of youth are first, and foremost. This committee would have expertise, resources and funding to consult and advise on the progress of the mental health reform. More youth and families can have a say in the delivery of mental health services and in how community resources are developed with the independent voice they would have with this committe.

An external advisory committee specifically for child and youth mental health is necessary at this time because of the implementation of the Plan. It might not need to be permanent but should be a separate standing committee and not a responsibility of the actual Child and Youth Officer.

## 8.3 Redirect funds towards capacity building at the local level

The Child and Youth Mental Health Plan does not allow for direct money for building partnerships although it sees this as a critical element of success. MCFD is presently recruiting mental health workers to serve in all the communities across the province. This can benefit youth and their families, but in order to create strong and caring communities more needs to be done in reinforcing or developing relationships. Fragmentation, territoriality, stigma can be addressed through better integration between mental health practitioners, primary care workers, schools, consumer groups, generic groups, etc. The responsibility of developing working relationships needs to be seen as a valuable time investment and not an add-on to the already overstretched community-based actors.

As more and more not-for profit associations are becoming involved in direct care through support and service delivery, it is important to recognize that they face challenges that can compromise the level and the quality of care given to youth with severe mental illness. A closer look at funding mechanisms of community-based organizations that offer services to youth and their families is required.

## 8.4 Survey community resources available for youth with mental illness

The non-profit sector is often responsible for community resources but little attention is paid to what resources are available, and whether or not initiatives are sustainable. This sector faces many challenges: inability to access core-funding, difficulty in recruiting highly skilled personnel because of low wages, gaps in services and programs, and, increased demands as the shift to community-based resources increases in social services. A survey of the resources used, including patterns of usage would help with funding decisions but also would inform best practices. At the present time the focus in research on community-based initiatives is based on clinical considerations but not on community capacity. What do communities need to care for youth with severe mental illness outside direct mental health services? Are consumer groups able to support and do advocacy work in all regions of the province? What resources are available when families are not able or available to the youth? Which schools have peer counselling and do they have the ability to help with transition from acute care back to school for youth?

Knowing what resources are available is one aspect of this policy option. Knowing which resources are used and by whom, also needs to be investigated. This could be done through community participatory research that has the added advantage of educating and engaging participants.

# 9 Evaluation and Recommendations

The evaluation of the policy alternatives uses some of the criteria found in the resource kit on accountability and performance indicators for mental health services and supports prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health. Four criteria have been chosen and are defined below. Each policy alternative will be evaluated against those criteria to help guide our recommendations.

### 9.1.1 Criteria

- Acceptability: This criterion assesses if the care or the service meets the expectations of the consumer, the family, the community, the providers and paying organizations. Some of the indicators are consumer satisfaction, consumer and family involvement in the treatment in the planning and delivery, and cultural sensitivity.
- Continuity: Continuity is the ability to provide uninterrupted, coordinated services across programs, practitioners, organizations and the different levels of services, over time. Some indicators of continuity are the mechanisms in place to insure transitions, community follow-up after discharge from an acute care or tertiary care facility, a documented discharge plan and a single point of accountability.
- Efficiency: Do the desired results achieve a cost-effective use of resources? Indicators for this criterion are the cost per client and community/institutional balance.
- Accountability: An important aspect of accountability is how well priority groups are served. Indicators are clear expectations among stakeholders, and open and transparent relationships.

All the policy options satisfy the above criteria. The evaluation of the different options to address the lack of community-based resources to facilitate the care of youth with severe mental illness has been done using findings from the literature and the survey of the needs of youth, their

families and the communities against the resources available at present. It is recommended that the province consider all the options for the reasons given in the discussion below.

### 9.1.2 Recommendations

The policy alternatives all have important contributions to make towards the reform of mental health and the development of resources for youth with severe mental illness. They are not mutually exclusive and can be implemented over time, with priority given to reinstating the external advisory committee for child and youth mental health.

Reinstatement of the external advisory committee meets all the criteria and is easy to implement. It primarily insures the full participation of youth and families in the planning and implementation process, which will have a direct effect on the continuity of service. Indeed, youth and families will be able to identify, from their perspective, gaps in services as well as the resources needed to reduce them. By giving a strong independent voice to youth and his or her families, everyone benefits. Youth, families and communities, as well as government agencies gain a better understanding of the needs of mental health consumers and better decisions can be made in the allocation of limited funding. It is cost-effective and contributes to a more open and accountable mental health reform process.

In the long tem, the ministries involved in the Child and Youth Mental Health Network can re-direct funds towards capacity building. This policy option speaks directly to the acceptability criteria. With more financial resources allocated to this aspect of the Plan, families and communities will be able to be more involved in caring for their youth. This builds the expertise at the community level, which will be reflected in the quality and continuity of care. It reduces risk factors and reinforces the protective ones. With limited financial resources, it could be argued that is not feasible without reducing services but the implementation of a new initiative, so dependent on community-based resources, requires adequate funding. More efforts from the government in reinforcing capacity would also meet the accountability criteria by investing where the service will be delivered and by giving the means to communities to create the environment needed to care for their youth. Also in the long term, the provincial government needs to do a

survey of community resources. This would help consumers accessing care more efficiently, and would help in the planning or improving resources.

The development and implementation of a communication strategy is a policy option that needs to be implemented in the near future and on an ongoing basis. The first strategic shift of the Ministry of Children and Family Development is to have more open and transparent relationship with staff, media, community partners and the public. This would involve working together with other ministries to help move from a "reactive and defensive culture" (CYMHP, revised 2004, Appendix D) to a consultative approach to supporting children and families. It meets the accountability criteria as well as the acceptability criteria. The communication strategy is not only about mental illness but also about what services and resources are available, who is involved in delivering them, and the role of government and communities in shaping the care of youth with severe mental illness. It is a cost effective option and will probably not require much investment from the provincial government, as an information strategy on mental illness is already part of the Plan. It needs to be augmented to include information on resources, stakeholders and processes.

# 10 Conclusion

The implementation of the Child and Youth Mental Health Plan is the opportunity for the province of British Columbia to create equal partnerships with families and communities. Caring for youth with severe mental illness is a challenge for all. The work required to develop and reinforce the capacities and resources of communities to meet their needs will have great social impact. With the shift from an institutional-based model to a community-based model, comes the need to adopt a youth, family and community perspective.

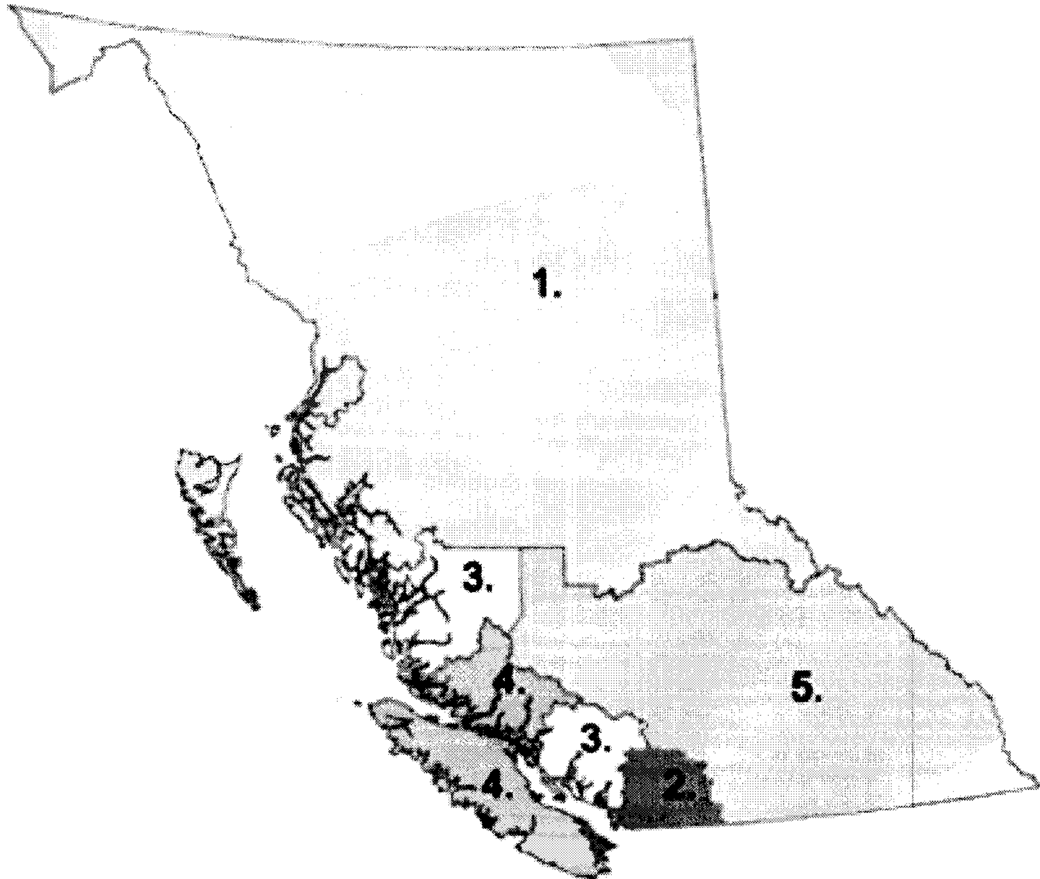
A better understanding of youth and mental illness combined with an evidence-based approach is shaping clinical practices. A better understanding of communities will contribute to care that is more efficient and sustainable. This project identifies policies that will increase the knowledge about communities, but also about mental illness and actual resources. All will benefit from the exchange of information and this can lead to stronger partnerships in the future. Because partnerships take time and dedication, it is important to invest in them at such a crucial moment as the implementation of a reform. This can only strengthen the participation of the community-based partners who are feeling overstretched and often unable to respond to increasing need.

This study illustrates that a debate needs to take place in a more open fashion about residential, institutional-based, and community-based care. Evidence-based practices need to be understood by not only health care practitioners but also by community partners.

# Appendices

## Appendix A: Map of provincial administrative regions.

*Figure A-1: Map of administrative regions of the Ministry of Children and Family Development*




*Source: Ministry of Children and Family Development website.*

1. North
2. Vancouver Coastal
3. Fraser
4. Vancouver Island
5. Interior

# Appendix B: Admissions at MATC by region and program, 2004-2005

*Table B-1. Total Admissions at MATC by region and programs, 2004-2005*

**All Regions and all Programs, Crosstabulation, 2004-2005**

| | | | Program | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | ARCC | BF | CCP | DALA | DNR | RPC | RPN | RR | Total |
| Region | Fraser | Count | 4 | 18 | 6 | 5 | 9 | 4 | 49 | 40 | 135 |
| | | % within Region | 3.0% | 13.3% | 4.4% | 3.7% | 6.7% | 3.0% | 36.3% | 29.6% | 100.0% |
| | | % within Program | 80.0% | 75.0% | 31.6% | 19.2% | 100.0% | 100.0% | 77.8% | 59.7% | 62.2% |
| | | % of Total | 1.8% | 8.3% | 2.8% | 2.3% | 4.1% | 1.8% | 22.6% | 18.4% | 62.2% |
| | Vancouver Coasta | Count | 0 | 6 | 4 | 14 | 0 | 0 | 12 | 14 | 50 |
| | | % within Region | .0% | 12.0% | 8.0% | 28.0% | .0% | .0% | 24.0% | 28.0% | 100.0% |
| | | % within Program | .0% | 25.0% | 21.1% | 53.8% | .0% | .0% | 19.0% | 20.9% | 23.0% |
| | | % of Total | .0% | 2.8% | 1.8% | 6.5% | .0% | .0% | 5.5% | 6.5% | 23.0% |
| | Vancouver Island | Count | 0 | 0 | 6 | 0 | 0 | 0 | 0 | 2 | 8 |
| | | % within Region | .0% | .0% | 75.0% | .0% | .0% | .0% | .0% | 25.0% | 100.0% |
| | | % within Program | .0% | .0% | 31.6% | .0% | .0% | .0% | .0% | 3.0% | 3.7% |
| | | % of Total | .0% | .0% | 2.8% | .0% | .0% | .0% | .0% | .9% | 3.7% |
| | North | Count | 0 | 0 | 2 | 1 | 0 | 0 | 2 | 9 | 14 |
| | | % within Region | .0% | .0% | 14.3% | 7.1% | .0% | .0% | 14.3% | 64.3% | 100.0% |
| | | % within Program | .0% | .0% | 10.5% | 3.8% | .0% | .0% | 3.2% | 13.4% | 6.5% |
| | | % of Total | .0% | .0% | .9% | .5% | .0% | .0% | .9% | 4.1% | 6.5% |
| | Interior | Count | 0 | 0 | 1 | 6 | 0 | 0 | 0 | 2 | 9 |
| | | % within Region | .0% | .0% | 11.1% | 66.7% | .0% | .0% | .0% | 22.2% | 100.0% |
| | | % within Program | .0% | .0% | 5.3% | 23.1% | .0% | .0% | .0% | 3.0% | 4.1% |
| | | % of Total | .0% | .0% | .5% | 2.8% | .0% | .0% | .0% | .9% | 4.1% |
| | Other/Unknown | Count | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| | | % within Region | 100.0% | .0% | .0% | .0% | .0% | .0% | .0% | .0% | 100.0% |
| | | % within Program | 20.0% | .0% | .0% | .0% | .0% | .0% | .0% | .0% | .5% |
| | | % of Total | .5% | .0% | .0% | .0% | .0% | .0% | .0% | .0% | .5% |
| Total | | Count | 5 | 24 | 19 | 26 | 9 | 4 | 63 | 67 | 217 |
| | | % within Region | 2.3% | 11.1% | 8.8% | 12.0% | 4.1% | 1.8% | 29.0% | 30.9% | 100.0% |
| | | % within Program | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | | % of Total | 2.3% | 11.1% | 8.8% | 12.0% | 4.1% | 1.8% | 29.0% | 30.9% | 100.0% |

*Note: ARCC: Community Based program; BF: Bifrost, non-residential; CCP: Crossroads Care Program, residential; Dala: residential; DNR: Dala, non-residential; PPC: Response, community; RPN, Response non-residential; RR: Response, residential.*

# Appendix C: Admissions at MATC by gender and program

*Table C-2. Total admissions at MATC by gender and all programs, residential and non-residential, 2003-2004*

**All Programs by Gender Crosstabulation-2003-2004**

| | | | Gender | | Total |
|---|---|---|---|---|---|
| | | | F | M | |
| Program | BF | Count | 9 | 16 | 25 |
| | | % within Program | 36.0% | 64.0% | 100.0% |
| | | % within Gender | 9.6% | 10.1% | 9.9% |
| | | % of Total | 3.6% | 6.3% | 9.9% |
| | CCP | Count | 9 | 20 | 29 |
| | | % within Program | 31.0% | 69.0% | 100.0% |
| | | % within Gender | 9.6% | 12.7% | 11.5% |
| | | % of Total | 3.6% | 7.9% | 11.5% |
| | DALA | Count | 12 | 11 | 23 |
| | | % within Program | 52.2% | 47.8% | 100.0% |
| | | % within Gender | 12.8% | 7.0% | 9.1% |
| | | % of Total | 4.8% | 4.4% | 9.1% |
| | RPN | Count | 18 | 39 | 57 |
| | | % within Program | 31.6% | 68.4% | 100.0% |
| | | % within Gender | 19.1% | 24.7% | 22.6% |
| | | % of Total | 7.1% | 15.5% | 22.6% |
| | RR | Count | 46 | 72 | 118 |
| | | % within Program | 39.0% | 61.0% | 100.0% |
| | | % within Gender | 48.9% | 45.6% | 46.8% |
| | | % of Total | 18.3% | 28.6% | 46.8% |
| Total | | Count | 94 | 158 | 252 |
| | | % within Program | 37.3% | 62.7% | 100.0% |
| | | % within Gender | 100.0% | 100.0% | 100.0% |
| | | % of Total | 37.3% | 62.7% | 100.0% |

*Note: BF: Bifrost, non-residential; CCP;Crossroads Care Program, residential; Dala, residential; RPN: Response non-residential; RR: Response Residential.*

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