



**CALEDON**  
INSTITUTE OF SOCIAL POLICY

# **Knowledge Exchange for Mental Health**

*by*

**Sherri Torjman and Anne Makhoul**

**June 2013**

# **Knowledge Exchange for Mental Health**

*by*

**Sherri Torjman and Anne Makhoul**

**June 2013**

Copyright © 2013 by The Caledon Institute of Social Policy

ISBN 1-55382-578-0

Published by:

Caledon Institute of Social Policy  
1354 Wellington Street West, 3rd Floor  
Ottawa, ON K1Y 3C3  
CANADA  
Tel./Fax: (613) 729-3340  
E-mail: [caledon@caledoninst.org](mailto:caledon@caledoninst.org)  
Website: [www.caledoninst.org](http://www.caledoninst.org)  
Twitter: @CaledonINST

## *Table of Contents*

Executive summary	1
Canadian landscape	4
Philosophical and conceptual underpinnings	6
Target populations	7
Core methodologies	8
i. Mental health promotion and early intervention	8
ii. Service improvements	9
iii. Community-based supports	9
Key challenges	10
Challenge #1: Responsiveness	11
i. Youth focus along the child/youth/adult continuum	11
The issue	11
Opportunities for knowledge exchange	11
Supporting evidence	12
ii. Complex needs related to mental health	16
The issue	16
Opportunities for knowledge exchange	16
Supporting evidence	17
iii. Diversity and cultural appropriateness	19
The issue	19
Opportunities for knowledge exchange	19
Supporting evidence	20
Challenge #2: Resources	24
i. Human resources	24
The issue	24
Opportunities for knowledge exchange	24
Supporting evidence	25

ii. Financial resources	28
The issue	28
Opportunities for knowledge exchange	28
Supporting evidence	29
iii. Relative distribution among components of the system	31
The issue	31
Opportunities for knowledge exchange	31
Supporting evidence	32
Challenge #3: Governance and Accountability	35
i. Collaboration and coordination	35
The issue	35
Opportunities for knowledge exchange	35
Supporting evidence	35
ii. Monitoring and assessment	39
The issue	39
Opportunities for knowledge exchange	39
Supporting evidence	39
iii. Receptive environment	44
The issue	44
Opportunities for knowledge exchange	44
Supporting evidence	44
Future trends in mental health treatment and service management	49
Conclusion	51
References	52
Appendix A: Provincial/Territorial Mental Health Strategies	53
Appendix B: Highlights of Related Initiatives	55

## *Executive summary*

This report on provincial and territorial mental health strategies was written by the Caledon Institute of Social Policy at the request of the Graham Boeckh Foundation. The Foundation aims to improve mental health care in Canada by strategically leading and funding projects.

The majority of jurisdictions in Canada have introduced formal mental health strategies. While each province and territory states its objectives in unique ways, these can be summarized as several distinct, but related, goals. They all seek to enhance the mental health of the overall population, intervene early for people considered to be at risk of mental health problems, improve the quality and quantity of mental health treatment services, and ensure the availability of adequate community supports.

Despite the unique approaches, the report explores the challenges that are common to all provinces and territories. These challenges are discussed within the context of three main clusters related to responsiveness, resources, and governance and accountability. Each of these three core clusters is broken down, in turn, into three sub-sections.

This paper argues that within each challenge area, there is a wide range of opportunities for the exchange of knowledge. Such exchange would help improve the quality of service, raise the bar of provision throughout the country by building on good practice and make better use of scarce resources. One area that warrants further exploration, for example, involves the needs of youth and the interventions that have proven most effective for this group.

The training and upgrading of human resources is an issue of constant concern that potentially could lend itself to a broader pan-Canadian approach. A related question involves informal training for family members and natural supports who often must deal with difficult circumstances with little information or assistance.

In addition to challenges related to human resources, all jurisdictions struggle with the problem of sufficient funding. The lack of resources is compounded by concerns regarding their distribution among various components of the mental health system. A discussion about a better weighting of treatment relative to community investments would be welcome. There are also questions about adequate investment in youth in light of the current attention being directed to the needs of seniors.

The various mental health strategies recognize the importance of a joined-up approach among their component parts and have proposed ways to effect this coordination. The extent to which this objective is working well in practice is unknown, given current reporting requirements that typically involve 'vertical' accountability up and down the chain rather than 'horizontal' accountability through joint initiatives. An informed conversation on successful evaluation methodologies and practicable indicators of progress employed by individual jurisdictions would likely be useful to all.

When it comes to creating a receptive environment for mental health, there are several areas in which knowledge exchange would be helpful. Jurisdictions engaged in efforts to reduce stigma can

identify which messages appear to resonate with the public and which approaches appear to have been less effective. Similarly, provinces and territories that have employed caseload and cost-benefit data can report on the types of arguments that have successfully led to increased investment in mental health treatment services and community-based supports.

The key areas for knowledge exchange in all major cluster areas are summarized below.

### ***Challenge #1: Responsiveness***

#### *i. Youth focus along the child/youth/adult continuum*

- there is often a gap or ‘cliff’ that youth face as they move out of the child category of service provision
- adult-associated conditions may be missed or misdiagnosed when they present in children or young people
- the quality and effectiveness of services directed toward youth should be explored and should incorporate their voice as part of this discussion.

#### *ii. Complex needs related to mental health*

- exclusion lists often include persons with mental illness or those with a “secondary emotional problem”
- helping systems need to be more accepting of persons with complex needs, particularly around mental health.

#### *iii. Diversity and cultural appropriateness*

- the principle of consumer-directed care faces significant challenges when it comes to persons living with mental illness; there is a need to share knowledge and practice around client-centred approaches
- unique responses to diversity around language, culture and gender identity are being tested throughout the country
- individualized funding is rarely mentioned as a possible option in mental health strategies.

### ***Challenge #2: Resources***

#### *i. Human resources*

- the ongoing training and upgrading of personnel, especially around new treatment methods and technologies, is essential
- in addition to formal training, it would be helpful to share information around handling tough situations encountered in mental health
- knowledge exchange may help improve the provision of information and supports for family members.

*ii. Financial resources*

- an informed discussion would be valuable on how best to make the case for crucial financial investments in mental health.

*iii. Relative distribution among components of the system*

- there is a need to ensure that sufficient funds are directed toward community supports given that current spending focuses largely on treatment services
- it is essential to create links among diverse elements of the formal mental health strategy as well as with related initiatives within the jurisdiction
- the mental health needs of youth must be adequately served in an aging society with growing attention being paid to seniors' mental health.

***Challenge #3: Governance and accountability***

*i. Collaboration and coordination*

- jurisdictions need to know whether their continuum of services is well coordinated in practice
- it is essential to ensure that the youth perspective is being taken into consideration in this assessment.

*ii. Monitoring and assessment*

- challenges arise in assessing the impact of mental health treatment, especially if results may not be immediately apparent
- gathering quantifiable evidence of the impact of health promotion is not easy – e.g., assessing something that presumably was avoided
- information can be shared on successful evaluation methodologies and practicable indicators of progress.

*iii. Receptive environment for mental health*

- there is a need for more information on methods to assess or even measure reduced stigma
- it would be helpful to share knowledge on the arguments that have led to increased investment in mental health treatment services and community-based supports.

The report concludes with a summary of major considerations for the future. These include treatment advances such as client-centred care and individualized funding; the use of technology such as electronic records and tele-services for remote areas; and research innovations that affect both mental health treatment and accountability.

Finally, in carrying out a pan-Canadian study of this nature, it is not unusual to find that provinces and territories have their own unique terminology to refer to certain conditions or factors. Throughout the document, we have tried to use terms that are commonly employed in jurisdictions across the country. While it is likely that certain terms found in this report assume different meanings in various provinces and territories, we have made an effort to employ common language where possible and appropriate.

## *Canadian landscape*

The purpose of this report is to present an overview of the mental health strategies introduced in recent years by provincial and territorial governments.

The document briefly describes the major philosophical and conceptual underpinnings that comprise the foundation of these mental health strategies. It also highlights the goals and objectives guiding the various frameworks. The paper points to target groups of special concern and to diverse interventions that provinces and territories will employ or currently are using to meet their stated objectives.

Mental health issues are finally gaining prominence on the public agenda and at the policy level. Several factors appear to have contributed to this momentum.

The work of the federally appointed Mental Health Commission of Canada was instrumental in raising this awareness. The Commission is an independent arms-length organization. It was established by the federal government in 2007 in response to a key recommendation in *Out of the Shadows at Last*, the final report of the Standing Senate Committee on Social Affairs, Science and Technology. Released in May 2006, the report surfaced many issues including the:

- lack of consistent and widespread collaboration among distinct components of the health care system and related social services
- insufficient supports for persons living with mental illness and their families
- inadequate funding relative to the social and economic impact experienced by individuals living with mental illness, their families and natural supports, and by society more generally.

In June 2012, the Mental Health Commission published a substantial report on the state of mental health entitled *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. The document marked the first time that a shared vision on mental health was produced in the country. It put forward a set of priorities to guide the efforts of the public, private and nonprofit sectors; service delivery agencies; policy experts; and members of the public to improve mental health outcomes.

The Strategy was developed in two distinct phases. In 2009, the Commission's release of *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada* marked the completion of the first phase. The Framework set out a vision and broad goals that reflect emerging consensus within the diverse mental health community. The second phase was designed to complement local mental health initiatives, urging that "strategic investment, clear indicators of progress and a strong social movement are needed to drive change" [MHCC 2012: 12].

The Commission has led several other efforts, including the:

- development of a 10-year anti-stigma and anti-discrimination initiative

- creation of a knowledge exchange centre – a web resource to access evidence-based information on mental health and mental illness
- carrying out of several research demonstration projects including a major effort on mental health and homelessness, which employs the Housing First model of intervention.

In 2003, British Columbia became the first province to implement a Child and Youth Mental Health Plan, which doubled the funding for and increased access to an enhanced continuum of services and supports. This initiative was followed in 2010 by *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use*, which covers the lifespan. The plan is led by the BC Ministry of Health and Ministry of Children and Family Development in collaboration with other ministries and community partners.

The majority of provinces and territories in Canada have now introduced strategies that focus explicitly on mental health. These include Newfoundland and Labrador, Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba, Alberta and the Northwest Territories.

Nunavut’s mental health strategy is embedded in its Public Health Strategy. Nunavut also announced a Suicide Prevention Strategy effective September 2011 to March 2014. Prince Edward Island and Saskatchewan are in the process of developing their respective frameworks; Quebec and Newfoundland and Labrador are updating their existing strategies. A list of strategies and associated publication dates is attached as Appendix A.

The various mental health initiatives throughout the country have evolved from a unique context in each jurisdiction. In some cases, the strategy is linked to a related health care effort currently under way. Stark numbers and the sheer enormity of the problem are also key driving forces.

In Ontario, for example, *Open Minds, Healthy Minds* is aligned with the *Excellent Care for All Act*, which became law in June 2010. The Act ensures the use of best practices to organize health care delivery around the person in the most efficient, integrated way. The mental health strategy’s first three years (2011-14) are devoted to children and youth through interventions that focus on protecting them “from the many associated costs of mental illness and addictions.”

In 2010, the Minister of Health and Wellness in Nova Scotia appointed an Advisory Committee of individuals with personal and professional experience in mental health and addictions to make recommendations that would help shape the government’s Mental Health and Addictions Strategy. Summaries of public consultations, research and best practices were contained in the April 2012 *Come Together* report, laying the foundation for *Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians*, released in May 2012.

The *Action Plan for Mental Health* in New Brunswick builds on the philosophy of collaborative governance established through the province’s Economic and Social Inclusion Plan. The Action Plan was designed to improve the social determinants of health; provide individualized care to persons in need; improve mental well-being in the family, community and workplace; and reduce the stigma associated with mental illness.

Evidence has also played a significant role in driving the development of mental health strategies in several jurisdictions. Alberta's 10-year visioning statement *Positive Futures – Optimizing Mental Health for Alberta Children and Youth – A Framework for Action, 2006-2016* informed the development of its three-year Children's Mental Health Plan for Alberta, released in 2008. The work undertaken through this period helped guide the province's overall mental health strategy, *Creating Connections: Alberta's Addiction and Mental Health Strategy*, released in September 2011.

With a few notable exceptions such as breast cancer and heart disease, Nunavut's health status indicators are substantially below the Canadian average. The suicide rate is the highest per capita in the country. At the same time, the population of Nunavut is young and growing. The Government of Nunavut deemed it imperative to lay the groundwork for healthy population development.

### ***Philosophical and conceptual underpinnings***

Despite the unique circumstances in each jurisdiction, some common threads bind together these diverse efforts.

Most of the strategies make explicit their philosophical underpinnings – and there are some clearly related themes. The individual with the mental health concern lies at the heart of the framework. The system of services and supports must be responsive to the needs of that person. In fact, several of the plans point to how they are shifting explicitly to client-centred approaches, which put the consumer at the front and centre of the plan. The consumer is an active agent in the treatment and healing process.

Empowerment is identified, for example, as a major guiding principle in Quebec. Empowerment means recognizing that people are able to make choices and participate actively in decisions that affect them. The Quebec framework refers to the fact that recovery is a highly personal process in which individuals take control of their lives and seek fulfillment despite the challenges associated with their illness.

While all strategies have adopted a client-based or consumer-centred focus as a philosophical foundation, several jurisdictions also appear to have common conceptual underpinnings. These generally take the form of two linked themes related to population health and the social determinants of health.

Population health is an approach that seeks to improve the health of the entire population and to reduce health inequities among population groups. In order to achieve these objectives, it takes into account the broad range of factors and conditions that have a strong influence on health, beyond the health care system itself.

Ontario, for example, sets out a comprehensive strategy for mental health and addictions. *Open Minds, Healthy Minds* states its vision as: An Ontario where every person enjoys good mental

health and well-being throughout their lifetime, and where all Ontarians with mental illness or addictions can recover and participate in welcoming supportive communities.

Several ministries are working to ensure that the social determinants of health are addressed as the province develops and implements standards (e.g., Early Psychosis Intervention) and identifies best practices through service collaboratives. The strategy is holistic and covers a number of objectives including: improving mental health and well-being for all Ontarians; healthy and resilient inclusive communities; access to services; early identification and intervention; and high quality, integrated, person-directed health and other human services.

Other jurisdictions, such as Alberta, include an explicit focus on healthy communities in addition to designated populations. The province commits to improving the mental health of the population by enhancing the quality of the environments in which Albertans work, learn, live and play.

The social determinants of health approach is the second conceptual building block to which several jurisdictions make explicit reference. The World Health Organization defines the social determinants of health as the conditions in which people are born, grow, live, work and age, including the health system. Jurisdictions such as Nunavut that make reference to this approach are concerned not just with the prevention and treatment of mental illness but also with the root causes of poor health, including poverty.

### *Target populations*

Even with a population approach as the major conceptual foundation, all provinces and territories refer to specific groups that are of particular interest. Almost all identify children and youth as top priorities. Their respective areas of work around children and youth are discussed more fully below.

Other target groups are identified as well. Most jurisdictions include plans to improve the quality and accessibility of services for people with substance use problems. Newfoundland and Labrador, for example, sets out the targets of its interventions to include:

- children and youth – timely access to an array of evidence-based assessment and treatment services
- women affected by gender-based violence, low income and income inequality, low or subordinate social status and the unremitting responsibility for the care of others
- older adults – current service delivery models do not reflect the complex and changing mental health needs of this group
- Aboriginals – Treaty negotiations, loss of land to settlers and the organization of power and governance.

Manitoba pledges to remove barriers to service for Aboriginals and newcomers to Canada. Reducing stigma and social prejudice with an initial focus on health care providers, children and youth is a priority focus.

Alberta also identifies Aboriginals and newcomers as populations of interest as well as those considered at risk of developing mental health problems.

British Columbia released *A Path Forward; BC First Nations and Aboriginal People's Mental Wellness and Substance Use – 10 Year Plan* in 2013.

### ***Core methodologies***

While the proposed actions within the diverse mental health strategies are broad-ranging, they generally fall into one of three categories. The first set of actions involves efforts to promote mental health and prevent the onset of mental illness. The second group of initiatives seeks to improve the quality and quantity of mental health treatment services. The third group of measures is concerned with the provision of community supports.

#### *i. Mental health promotion and early intervention*

First are the actions to enhance the health of the population through promoting good health and emotional well-being, and building healthy communities. The purpose of these interventions is to foster well-being, prevent the onset of mental illness where possible and intervene early upon the identification of potential or actual mental health problems.

Several jurisdictions have introduced mental health programs in schools in an attempt to reach young people at an early age. As part of its SchoolsPlus program, for example, Nova Scotia is placing mental health clinicians in all school boards in the province to identify and treat mental health problems of children and youth at the earliest possible stages. It is also expanding across the province the successful Strongest Families program, which provides telephone coaching to families with children with behavioural or anxiety difficulties. At the community level, Nova Scotia is extending its toll-free crisis lines across the province to ensure that people with mental health and addictions concerns are able to talk immediately to a designated helper.

Alberta is expanding the reach of its Mental Health Capacity Building in Schools Initiative. Its purpose is to establish projects that provide the staffing and support required to implement an integrated, school-based community mental health promotion, prevention and early intervention program. Projects are locally planned, coordinated and implemented through partnerships with Alberta Health Services Zones, school jurisdictions, parents, community agencies and other regional service providers. Begun in 2006 with five pilot test sites, the initiative currently funds 37 projects in 53 communities and 143 schools.

BC has introduced the FRIENDS for Life program sponsored by the Ministry of Children and Family Development. It is an evidence-based, school-based, anxiety prevention and resiliency program. There is an online parent component as well as three program levels available: Fun FRIENDS for children in Kindergarten and Grade 1, a child component for students in Grades 4 and

5, and a youth component for students in Grades 6 and 7. BC has also implemented Strongest Families, a telephone-based coaching program to support families with children who have mild to moderate behaviour problems, and the BC Healthy Connections Project to support vulnerable first-time mothers and their infants.

In addition to the measures identified in their respective mental health plans and strategies, all jurisdictions are engaged in various efforts to promote positive mental health in the population and among youth in particular. These related interventions are described in Appendix B. They include anti-bullying initiatives, measures for the early identification and treatment of autism, strategies for children and youth, health promotion programs, housing and homelessness efforts and enhanced recreational activities.

### *ii. Service improvements*

The second category of interventions consists of the broad range of actions that seek to deliver more effective services to individuals with mental health problems. In fact, most of the content of the mental health strategies and plans throughout the country is concerned with this component. Service improvements involve a number of dimensions.

In some cases, provinces and territories plan to enhance the supply of existing services in order to reach underserved areas, or to shorten lengthy wait times. In addition to bolstering the supply of services, all jurisdictions make reference to modifying their delivery. Some will be adopting a team approach to treatment while others will be enhancing access to psychiatric consultation or introducing dedicated emergency inpatient services. Tele-health is being expanded in BC, for example, to increase service access for children, youth, and families. Several jurisdictions noted the need for improved staff training in order to apply evidence-informed treatment methods.

### *iii. Community-based supports*

The third group of interventions involves a range of community supports whose purpose is to enable independent living in communities. Actions in this category include supported housing and peer supports to help people with mental illness transition successfully from the hospital to the community.

In addition to these three core methodologies, all provinces and territories are engaged in creating a more receptive environment for mental health. The purpose of this activity is twofold. Reducing stigma helps foster greater acceptance of people living with mental health problems and eases their integration into the community. A more receptive climate for mental health also makes it easier, at least in theory, to justify policy changes and new investments in this field.

## ***Key challenges***

The preceding description makes clear that each province and territory has embarked upon a unique pathway in its efforts to improve the quantity, quality and delivery of mental health services. The package of actual and proposed measures in each jurisdiction is shaped by a particular set of circumstances linked to its current configuration of programs as well as its distinct culture and population.

Despite the variation, there are some common challenges that all provinces and territories face in promoting mental health, improving mental health services and enhancing community supports. These challenges fall into three core clusters related to responsiveness, resources, and governance and accountability. Each cluster has a set of sub-themes, which are discussed more fully below.

### Responsiveness:

- youth focus within the child/youth/adult continuum
- complex needs related to mental health
- diversity and cultural appropriateness

### Resources:

- human resources
- financial resources
- relative financing among components of the mental health system

### Governance and Accountability:

- collaboration and coordination
- monitoring and assessment
- receptive environment for mental health.

The fact that these core challenges related to mental health are common to all provinces and territories means that there are many potential opportunities for knowledge exchange. There is a wide range of concerns around which it would be helpful to have an informed pan-Canadian conversation.

It may even be worthwhile down the road to explore more formal approaches to knowledge exchange. The Ontario Centre of Excellence for Child and Youth Mental Health, for example, offers a set of learning modules to all professionals working in the mental health field around common themes of interest. These include the application of evidence-informed practice and the monitoring and evaluation of outcomes.

Beyond joint learning, a recent report published by the Young Foundation in the UK argues that society's growing ability to mobilize knowledge from different fields and sources is beginning to show the potential of a 'knowledge commons' in health care. The commons would involve an open system of knowledge with researchers, practising clinicians, patients, their families and communities all involved in capturing, refining and utilizing a common body of knowledge in real time [Loder, Bunt and Wyatt 2013].

## ***Challenge #1: Responsiveness***

### *i. Youth focus along the child/youth/adult continuum*

#### *The issue*

Most jurisdictions make reference in their respective mental health strategies to the importance of focusing on youth and adolescents, and several note these groups as priority populations.

#### *Opportunities for knowledge exchange*

Children and youth are identified as top concerns in virtually all jurisdictions. But it is not clear how effective these strategies actually are or will be when they are implemented. There clearly is potential for knowledge exchange with respect to the needs of youth and the interventions deemed most effective for this group.

In some cases, it is difficult to separate the actions intended for children from those targeted specifically at youth. Several jurisdictions are grappling with this distinction and are trying to tackle the problem through strategic actions focused on key transition points.

While the explicit focus on youth is a positive development, it creates challenges for provinces and territories to ensure a smooth continuum along the way. Programs and services typically are organized by age. They are divided into children, youth, adults and seniors. The age criterion, occasionally in conjunction with other factors, effectively acts as a gateway to core services.

Unfortunately, however, the categorization of programs by age often creates inadvertent gaps by ending at one point and leaving individuals with nothing or with a void of several months or even years before the next set of services comes into play. Children often receive intensive services as part of family interventions and then move into an entirely different world at age 18 when the services either change dramatically or fail to exist altogether. The cut-off point or ‘cliff’ is a major problem in current service delivery.

Mental health problems present a challenge to this organizational structure because of the pivotal point of onset, which typically falls between two functional divides – adolescents and young adults. The divide is especially problematic in light of the fact that the onset and experience of acute symptoms of serious mental illness often occur when young people are in their early 20s. It is usually at this point when mental health professionals can differentiate adolescent depression from chronic mental illness, such as schizophrenia.

Conversely, there are circumstances where a mental health condition, such as attention deficit disorder, is considered to be most closely associated with childhood. Clinicians working with youth and adults require sufficient training to recognize and deal with later manifestations of the condition.

There is an emerging discussion as to whether it may be more helpful to look at mental health in terms of disease progression, not age. At age 10, for example, an individual living with mental illness may exhibit symptoms more commonly associated with a person in mid-adolescence. This approach runs contrary to current systems that involve the provision of service with strict cut-offs by age.

A pan-Canadian conversation focused explicitly upon the needs of youth and successful interventions would be invaluable. As mentioned earlier, Alberta is funding 37 projects throughout the province as part of its Mental Health Capacity Building in Schools Initiative. While it is still early in the process, preliminary lessons from this effort would be helpful to share. Do some approaches appear to be working better than others? Do certain conditions need to be in place in order to implement an effective program? How are the views of young people and their families being captured at both the developmental and evaluative phases of the interventions?

In fact, an exchange around youth voice more generally would be instructive. This crucial guiding principle may be somewhat challenging to apply in practice and shared experience around its application would be welcome. There may well be good ideas to share in terms of engaging young people in the design of various interventions and modifying supports in line with this feedback.

It would also be instructive to find out from young people involved in transitions between and among services what supports were particularly helpful to them and, conversely, where the system appeared to break down in terms of their needs. Though families and support networks are mentioned, there is no reference to seeking their feedback. It would be helpful to know which interventions appeared to work effectively with parents and with natural supports.

### *Supporting evidence*

**Ontario** has embarked upon its mental health strategy with a three-year plan that focuses on children and youth mental health. The *Child and Youth Mental Health Strategy* will ensure timely access for children, youth and families to high-quality services through actions that:

- implement a directory of services to improve public access and help children, youth and families find the right kind of services, and provide supports in select communities for families to navigate the system
- develop and put in place a wait time strategy
- help services respond more quickly by hiring more workers in child and youth mental health community-based agencies
- hire more youth mental health court workers to divert youth from the justice system to appropriate community-based services

- lay the foundation for long-term transformation of the child and youth mental health system and develop a set of outcomes and indicators that measure progress.

The *Child and Youth Mental Health Strategy* also seeks to close critical service gaps for vulnerable children and youth, children and youth at key transition points, and those in remote communities through actions that:

- enhance and expand the tele-psychiatry model and services to provide specialized expertise and serve children and youth, and their families, in remote, rural and underserved communities
- create 18 service collaboratives to support coordinated services for children, youth and adults, including a focus on children and youth in transition from inpatient to outpatient settings, between health and justice systems, and from child-focused to adult services.

*Moving on Mental Health – A system that makes sense for children and youth* (MOMH), released in November 2012, builds on *A Shared Responsibility – Ontario’s Policy Framework for Child and Youth Mental Health* (2007). MOMH seeks to transform the experience of children and youth with mental health problems and their families. Regardless of where they live in Ontario, they will know what mental health services are available in their communities and how to access the mental health services and supports that meet their needs.

In March 2013, Ontario set up its first-ever Premier’s Council on Youth Opportunities. Twenty-five young people from a variety of cultures, communities and backgrounds will be part of the council. They will provide advice on how to improve the delivery and design of government programs and services for youth and report on specific challenges. Council members will engage youth, young professionals and community partners to learn about specific challenges and share ideas about how to best support youth, including the development of a multi-year Ontario Youth Strategy to improve youth outcomes.

Significant work had been done in *Manitoba* around child and youth health before the July 2011 release of *Rising to the Challenge*. Responding to research indicating the first five years of life are critical to a child’s future development, the province implemented in 2000 the *Healthy Child Manitoba Strategy* – a network of programs and supports for children, youth and families. This nationally recognized strategy was set in legislation under the *Healthy Child Manitoba Act* in 2007.

Healthy Child Manitoba includes a component known as Knowledge Translation and Mobilization. This aspect reflects core commitments to child-centred policy, evidence-based decision making and community-government-university collaboration. The province’s poverty reduction and social inclusion strategy, *All Aboard*, also includes mental health considerations as does its work on recreation and on the prevention of youth suicide.

While Manitoba's strategy does not specifically identify the child to youth to adult transitions, it strives to achieve better cross-departmental and cross-sectoral planning within the overall goal of strengthening mental health and well-being across the age spectrum.

A major objective in *Alberta* is to foster the development of healthy children, youth and families. It seeks to improve the full continuum of services for children, youth and families by focusing on special populations within this group, on youth and adolescent mental health, and on access to addiction and mental health services. It will emphasize service coordination and collaboration as well as culturally effective strategies of intervention.

Earlier work in Alberta included the 2008 *Children's Mental Health Plan for Alberta, Three Year Action Plan, 2008-2011*. This three-year action plan aligned with many cross-sectoral initiatives such as the Mentoring Partnership Strategic Plan, Student Health, Bullying Prevention, Aboriginal Youth Suicide Prevention and Children and Youth with Complex Needs. It achieved progress on two major goals: creating equitable access and reducing wait times for mental health services, and improving access to services for at-risk children and youth.

Healthy children and families also figure prominently in the *BC* strategy. *Healthy Minds, Healthy People* places strong emphasis on children, youth and families as well as all people across the age span. It works to address mental health and substance use problems by reaching out to individuals at home, school and work. The strategy focuses on prevention, early intervention and treatment.

BC has also grappled with the child-youth transition issue. The province announced in November 2012 that young people would participate in decisions to improve the child welfare system and youth services. Its *Representative for Children and Youth Act* defines "child" as a person under age 19. "Youth" means a person who is 16 years of age or older but is under age 19.

A *Cross-Ministry Transition Planning Protocol for Youth with Special Needs* came into effect in November 2009. The Protocol is an agreement between nine government departments on how they will work together to support the transition to adulthood of youth with special needs. The Ministry of Children and Family Development planning guides include information on developing client-centered transition plans and helping youth better prepare for life as an adult.

An internal review of the effectiveness of Mental Health Transition Protocol Agreements (2002), which were developed to assist youth with mental health challenges to transition from Child and Youth Mental Health to adult mental health services, took place in 2012-13.

The Ministry of Children and Family Development Services in BC also recently indicated that it will be developing a two-year action plan to strengthen children and youth mental health services. The plan includes collaboration with stakeholders in Aboriginal communities to improve supports to that population. Key priorities include:

- improving access to community-based child and youth mental health services and managing wait lists
- increasing assistance for families navigating the system
- ensuring that the Ministry of Children and Family Development and the Ministry of Health have a consistent approach as children move between community mental health services and hospitals, and as youth transition to adult mental health services.

Healthy children and families are identified as *Nunavut*'s top priority. The objective translates into a number of specific measures related to healthy infants and young children. In terms of youth, in particular, the Territory will seek to reduce the number of young people experiencing mental, physical, emotional or sexual abuse, and decrease the incidence of youth engaged in risk behaviours.

## ***Challenge #1: Responsiveness***

### *ii. Complex needs related to mental health*

#### *The issue*

Several jurisdictions make reference to tackling complex needs, especially because mental health problems typically involve a multifaceted set of challenging circumstances.

#### *Opportunities for knowledge exchange*

Recognition of the importance of paying attention to persons with complex needs is a positive and significant development. Concerns remain, however, about some of the exclusions found in the current system.

A scan of services in one jurisdiction conducted several years ago by the Caledon Institute, for example, found that the eligibility criteria for special services for children excluded applicants with emotional, behavioural and psychiatric disorders; learning disabilities; speech and language disorders; neurological disorders; fetal alcohol syndrome without cognitive or physical disability; individuals who are sick but are becoming well; terminal illnesses; medical conditions which do not typically result in lifelong mental or physical disabilities; and applicants residing in First Nations communities.

Another cluster of services that provide supported living for persons with developmental disability excluded individuals with emotional, behavioural or psychiatric disorder without significant intellectual impairment; speech and language disorders only; learning disability only; neurological disorder; and borderline mental disability. Yet another example of exclusionary eligibility criteria involved certain vocational rehabilitation programs that do not accept individuals with a psychiatric disability or pervasive personality disorder.

In short, the list of exclusions embedded in specific programs often involves persons with mental illness or those with “secondary emotional problems.” The helping systems themselves need to be more accepting of persons with complex needs, particularly around mental health.

Part of the problem may arise from the lack of competence to deal with specialized needs linked to various forms of mental illness. This issue is considered in the next cluster of challenges around staff training. In the meantime, knowledge exchange around complex needs would help enhance the responsiveness of the various interventions.

Another complexity relates to the links between mental health problems and addiction. There is often higher-than-average representation of mental health and addictions problems in youth and adult correctional facilities.

## *Supporting evidence*

*Newfoundland and Labrador, New Brunswick, Ontario, Alberta* and *BC* have developed four- or five-level continuum of care plans to tackle complex needs. In some cases, specialized and complex needs are discussed as one point along the spectrum of the overall mental health plan.

In *New Brunswick*, for example, the Department of Health is promoting a collaborative model of care based on five levels of coordinated community and health system responses. It identifies disorders related to mental health and substance use as chronic diseases that require the following levels of intervention.

Level 1 refers to the public and community response. The broadest level of response, it includes resources that affect the prevention or management of mental illness on an individual and community.

Levels 2 and 3 comprise the primary and low-threshold response systems. These refer to all individuals, sectors, systems and organizations that have first contact with people who experience mental illness.

Level 4 focuses on specialized addictions and mental health care services. It involves components of the formal health care system and includes individual counselling, residential treatment and case management.

Level 5 refers to highly specialized services designed to meet the complex needs of persons who are not well served by mainstream services. This set of responses targets population groups for whom services and supports are inadequate, inaccessible or mismatched to client needs.

*Connecting the Dots* is a 2008 report by New Brunswick Child and Youth Advocate Bernard Richard on the problems experienced by children with complex needs. It reviewed seven complaint files and made 48 recommendations clustered around seven themes:

- creating conditions for greater political direction and accountability in child welfare
- integrating services
- providing community-based residential care
- decriminalizing youth with mental health disorders
- improving educational services that involve renewed efforts to engage and involve public health, child welfare and public safety officials in multidisciplinary approaches to inclusive education
- introducing measures to support families of youth-at-risk and children and youth with complex needs
- age discrimination in youth services.

*Ontario*'s mental health strategy notes the issue of complexity and promises to provide navigational support to 1,600 children and youth with complex mental health needs.

In *Alberta*, complex needs are discussed in the context of the interface between mental health and substance use. The province's *Addiction and Mental Health Strategy* commits to providing improved access to a seamless system of quality addiction and mental health services. The development of the strategy involved 16 ministries – in recognition of the fact that people with addiction and mental health issues tend to be served by several different government departments.

In order to address complex needs more effectively, Alberta plans to enhance evidence-based community interventions across the lifespan. Its goal is to ensure that people with complex needs have access to a full range of appropriate addiction and mental health services. Five core initiatives comprise this overall goal. They relate to:

- high-priority service gaps
- coordinated and shared responsibility
- integrated system case management
- justice and corrections
- a continuum of services and community supports.

*BC* makes reference to complex needs within a population health approach, focusing on groups in need rather than individuals. It uses a social determinants of health lens and places a strong emphasis on children. The province has identified four levels of action within its approach:

- all residents
- people vulnerable to mental health and/or substance abuse problems
- people with mild to moderate mental health and/or substance use problems
- people with severe and complex mental disorders and/or substance dependence.

The *Northwest Territories* similarly focuses much of its attention on complex needs within the context of substance use. Its mental health strategy identifies service gaps with respect to:

- a medical detoxification program
- more on-the-land mental health and addictions healing programs
- more community follow-up and aftercare following residential treatment
- supported independent living programs for individuals with chronic mental illness
- stronger integrated service management
- more programs targeted towards children and youth mental health and addictions issues
- programs to address specialized addictions treatment – e.g., crack cocaine, solvent abuse and the abuse of prescription drugs
- programs addressing mental health and addictions issues among the elderly
- more individualized mental health and addictions programs
- better use of existing infrastructure for mental health and addictions purposes
- early health promotion and intervention programs for children.

## ***Challenge #1: Responsiveness***

### *iii. Diversity and cultural appropriateness*

#### *The issue*

One of the major challenges that provinces and territories face in implementing their respective mental health strategies is to ensure that the core interventions – including both mental health services and community supports – reflect the diversity of the population. In fact, services should not only respect this difference but ideally should be shaped by it.

Diversity refers to ethnic and cultural factors as well as differences in language, religion, sexual preference and family formation. Canada’s population has become increasingly diverse in all these respects.

The challenge of responsiveness is not unique to the mental health field. While responsive approaches are important across the board, the need is doubtless more significant in mental health than in any other field.

Self-concept and self-esteem are linked intrinsically to notions of identity. Mental health interventions focus largely on an individual’s understanding and perception of self. Unless these unique and significant dimensions are appreciated, it is difficult to ensure the appropriateness of treatment interventions and community supports.

#### *Opportunities for knowledge exchange*

The implications of diversity are profound. While standards of good practice must be respected, there is clearly no place for one-size-fits-all solutions in which a single approach will work effectively across the board.

Several provinces and territories have made a concerted effort, as described below, to improve responsiveness through the explicit adoption of a consumer-directed approach to care. There is also a related body of work on patient activation in the mental health field. This is a positive development that generally is welcomed by the consumers of mental health services. Unfortunately, these jurisdictions may well encounter obstacles in the implementation of this approach.

The principle of consumer-directed care faces significant challenges when it comes to persons with mental illness who often are viewed by service providers, politicians or the public as lacking “good judgment” or unable to make decisions on their own behalf. The scales generally are tipped in favour of the professionals who hold the power in the relationship. The consumer voice is less likely to be heard in, let alone shape, the course of treatment.

Lack of genuine voice is a particular problem for youth who typically are deemed too young to know what they need or what is “good for them.” Their exclusion from decision-making processes related to service provision is a concern that has been identified in several fields.

Another way to ensure responsiveness is to provide money directly to consumers so that they can purchase precisely the services they prefer, especially when it comes to community supports. These so-called ‘individualized dollars’ allow the development of customized service plans. Individualized funding is, in fact, currently employed in selected disability-related programs throughout the country. It is certainly an important approach – particularly in light of the interest on the part of many consumers for self-directed supports.

However, individualized funding is rarely mentioned as a possible option in mental health strategies. The approaches tend to focus more on treatment plans developed by professionals rather than shaped by consumers. There appears to be an inherent tension around the notion of consumer-directed services when it comes to mental health. While this ideal is identified as a priority in many provincial and territorial strategies, it is not clear that it will be easy to translate this principle into practice.

It would be helpful for jurisdictions to create opportunities for sharing their respective experiences around client-centred approaches. A genuine conversation about the strengths and real challenges embedded in this methodology would be welcome. It would be useful to know which initiatives actually are effective in applying this principle in practice. It is also important to consider at what point and to what extent family and natural supports are engaged in the provision of both mental health treatment and community supports.

Finally, provinces and territories that have been particularly successful in responding to diversity – whether in language, culture, religious background or gender identity – should have an opportunity to share their respective efforts. Given that resources are always scarce relative to demand, how are jurisdictions providing mental health services, for example, in diverse languages? This area is particularly important if family members who are newcomers to the country are to be engaged in the early identification and treatment process.

### *Supporting evidence*

The concept of responsiveness is consistent with emerging client-driven approaches to services in which the concerned individual is deemed to be at the heart of the treatment process and is the primary driver of his or her own care. Several jurisdictions make explicit reference to this shift.

***Newfoundland and Labrador*** notes, for example, that consumers, families and significant others will be involved in care and treatment decisions affecting them. They will have the opportunity to participate in system-wide planning and evaluation.

Use of the word “consumer” is important: consumer, rather than patient, is used to signify an active role in self-care and to reflect the right to choice of services, the right to complain if a service is not adequate and the right to be consulted when new services are being designed, implemented and evaluated [NL 2005: 9].

This principle is backed up by several proposed actions that include the following:

- mental health and addictions programs that have written policies and procedures which identify the ways and opportunities that consumers and families can become involved
- self-help initiatives that are supported and promoted by the service system
- support for the role families and caregivers play in facilitating the health and well-being of individuals with mental illnesses, including addictions
- support for families to maintain their own well-being while in the caregiving role
- sustained community capacity building that is directed at maximizing the potential of consumer and family self-help and facilitating the involvement of other community resources.

In 2012 the Newfoundland and Labrador Health Minister's Advisory Council for Mental Health and Addictions, in partnership with the Mental Health Commission of Canada, addressed the need for a recovery-focused system. They developed a curriculum in recovery intended for formal and informal mental health leaders in community agencies, correctional services and regional health authorities. A consumer-led organization is developing the curriculum and a network of 173 physicians, managers and lead clinicians will inform the curriculum development and participate in the education program. Persons with lived experience and family members will also be involved in delivering the curriculum to this leadership group.

A major goal in *New Brunswick* is to realize potential through an individualized approach. This involves a shift to a recovery-based model of practice, with a focus on early identification as well as a changed organizational culture within the health care system to facilitate supported choice. People with lived experience of mental illness will contribute to health care service delivery.

The specific initiatives outlined in the New Brunswick strategy will create a system that is responsive to individual and community needs, and will recognize the importance of the continued input of persons experiencing mental illness and their loved ones. The provincial plan defines an individual's capacity to recover as the ability to live a meaningful life as he or she sees it, participate fully in treatment, receive services and supports that work best for that person and achieve greater quality of life.

*Manitoba* sets out as a key goal the social inclusion of people living with mental illness. As part of its mental health strategy, the province will encourage the meaningful engagement of people living with mental illness in the governance, system planning, delivery and evaluation of programs and services that affect their lives.

*British Columbia* has announced steps to allow consumers of mental health services to direct their own care. As of September 2013, families with children ages 12 to 18 who are eligible

for, or are receiving, autism funding will be able to choose to receive funds through either invoice payment or direct payment. This choice will give families greater capacity to purchase eligible services – such as those focusing on community-based inclusion and recreational skills – in order to meet the needs of older children and youth, and to promote successful transitions to adulthood.

The mental health plan in the *Northwest Territories* builds on work being undertaken by the Department of Health and Social Services to strengthen service delivery by “focusing on the person.” This focus means more responsive services, particularly for youth and persons with special needs, and greater sensitivity to diverse needs related to gender orientation and ethnicity.

Paying attention to diversity is another dimension of responsiveness. *Nova Scotia*’s mental health strategy discusses respect for diversity at some length. While the overall framework is founded on the basis of population health, its plan goes beyond this broad focus to identify unique actions for specific groups, including First Nations and Aboriginal citizens; African Nova Scotians; Acadian and Francophone Nova Scotians; new immigrants; and the Lesbian, Gay, Bi-sexual, Transgender and Intersex (LGBTI) community.

The province has established diversity implementation groups with representatives from the new immigrant, Acadian and Francophone, African Nova Scotian and LGBTI community to build cultural dimensions into the provision of mental health and addictions services. In respect of the LGBTI community, in particular, the Department of Education and school boards will respond positively to all reasonable student requests to establish or expand groups to support the safety and inclusion of marginalized students, including Gay/Straight Alliances. The province will continue to recruit more French-speaking clinicians to provide treatment and services to Francophone Nova Scotians.

*Manitoba* has identified cultural safety as one of the six key pillars of its plan leading the system to move beyond the traditional concept of being sensitive to the attitudes, beliefs, values and practices of different cultural groups to analyzing power imbalances and institutional discrimination.

*Alberta* has stated that the five strategic directions comprising its mental health framework will achieve better outcomes for First Nations, Métis and Inuit peoples. The priorities and initiatives are to be informed by an understanding of their histories, languages, cultures and specific circumstances as well as geographic location. In November 2012, Alberta indicated that it would be adding more than 80 new mental health and addictions workers across the province to help almost 4,000 Aboriginal children and young people gain better access to culturally appropriate mental health and addictions services.

*BC* released *A Path Forward; BC First Nations and Aboriginal People’s Mental Wellness and Substance Use – 10 Year Plan* in 2013. The strategy promises to develop a complementary and culturally distinct plan for BC’s Aboriginal populations that considers mental health, problematic substance use and young adult suicide.

In terms of responsiveness, a long-standing complaint among Northerners has been the lack of culturally appropriate mental health services. *Nunavut* will work toward addressing this problem by providing access to culturally sensitive counselling and offering more support for effective community-based wellness initiatives. It will expand the Nunavut Kamatsiaqtut Help Line, which will provide improved access to information, in all official languages, about risk and protective factors.

The *Northwest Territories* has declared that communities themselves are in the best position to determine their own culturally appropriate solutions. The Territorial strategy states that local mental health and addictions programs are to be guided by communities and supported by government rather than the other way around. Each area will have the opportunity to develop a Community Wellness Plan, taking into account the unique needs of its residents.

## ***Challenge #2: Resources***

### *i. Human resources*

#### *The issue*

The first category of challenges in mental health involves improving the responsiveness of services and programs. The achievement of this objective requires both human and financial resources, which comprise the second major cluster of challenges.

The need for resources is not unique to mental health. But it does come with unique demands, which are both generic to this field and specific to particular jurisdictions.

#### *Opportunities for knowledge exchange*

One of the generic challenges in mental health is to ensure that all professionals receive adequate training and upgrading on an ongoing basis. Practising professionals must remain current with new developments. The description of various mental health interventions makes clear that there is a large and substantive human resources agenda in the mental health field.

The training and upgrading of human resources are common concerns that potentially could lend themselves to a broader pan-Canadian approach. There may be a way of organizing certain components of human resource training on a collaborative basis in order to ensure instruction in the most up-to-date methods. Sharing costs involved in training may also reduce the financial burden for individual jurisdictions.

Alternatively, it may be possible to exchange knowledge through use of electronic methods, such as webinars. There may also be broader interest in sharing information about the use of technology, such as tele-health methods and electronic communications, in order to provide mental health services in rural and remote communities.

In addition to formal training, it may be helpful to engage in informal conversations about the kinds of challenges that mental health professionals and community support workers often face in the course of their work. These subjects would not focus on therapeutic interventions so much as methods of handling difficult circumstances, such a clinician striving to balance the rights of the person with lived experience and the clinical benefit of involving family members appropriately.

From a consumer perspective, there now exists an exhaustive array of government and other websites that contain mental health-related information. Such resources are expensive to establish and maintain, and their ultimate impact on mental health is uncertain. There is considerable opportunity for knowledge exchange around which information sources are regarded by users as credible and helpful.

Finally, it is of interest that most references with respect to improved training focus on the range of mental health professionals within the formal health care system. Equally important, however,

are training supports for family members in terms of coping with difficult situations at home, such as refusal to take medication, handling threats of violence or dealing with suicidal behaviour. Family members and natural supports could also benefit from information that helps them identify potentially serious mental health problems at early stages and know where to turn for help under these circumstances.

Family members also need assistance from support groups and chat rooms on websites so that they can access advice if required. There is work under way, for example, to provide this kind of online support to the informal caregivers of seniors with Alzheimer's and other forms of dementia. It potentially could be applied to other areas of mental health.

### *Supporting evidence*

**Newfoundland and Labrador** will establish a systematic process to enhance education and training among all stakeholders. A knowledge exchange network for the broad mental health and addictions community will be developed in 2013. **Nova Scotia** points to the need for a general understanding of illnesses and guidelines for sharing patient information. Training will be required in support of its strategy's first priority action area with respect to intervening and treating early for better results.

As part of this effort, the province intends to strengthen collaborative care delivered by primary health providers and professionals working in mental health and addictions. It will enhance education for Emergency Health Services paramedics in order to recognize and assist at the earliest possible time individuals with serious mental health and addictions problems.

Nova Scotia is in the process of developing implementation groups for diverse populations. It notes that concurrent disorders – when mental health problems and addiction are experienced together – are best treated in a complementary way.

**Quebec**'s mental health plans include the creation of primary care mental health teams – one geared towards youth and one for adults – in the *centres de santé et de services sociaux* (health and social service centres) with 50,000 inhabitants or more in their territory. Typically composed of general practitioners, psychologists, social workers and nurses, teams may also include other health professionals, such as occupational therapists, pharmacists and nutritionists.

The team approach effectively embeds ongoing training. Its 'shared care' approach encourages the active exchange of knowledge and expertise among providers and is based on principles of improved communication, clear roles, mutual support and respect. The teams share expertise and provide support to other primary care providers, including general practitioners and pediatricians both inside and outside the health and social service centres.

In addition, the shared care methodology encourages providers to better inform their clients and help them participate more actively in decisions that concern them. Consistent with this approach,

Quebec's Mental Health Plan introduced the role of "responding professionals." Often psychiatrists (but sometimes other professionals) act as expert resources for primary care mental health teams and providers with whom they share a service agreement. The role of these responding professionals is not to intervene directly in client care but rather to offer advice, guidance and leadership.

**Ontario** plans to enhance the capacity of first responders by assessing current training programs. It will develop:

- resources for referral and treatment
- appropriate common screening and assessment tools
- best practices for early identification and intervention
- standardized roles and competencies.

Ontario has also pledged to strengthen family health care by training providers on early identification and the recovery approach to care. The province will review and identify best practices, new compensation models and incentives, and tools to support screening, treatment and the connection to specialized services.

**Alberta** has identified workforce development as one of seven enablers necessary for building the organizational capacity and infrastructure of the mental health care system. The province also raises the issue of information sharing, particularly around new information technologies. A related challenge is to ensure that staff protect the privacy of patients by understanding and respecting privacy protocols.

**BC** will focus on training in order to enhance the role and effectiveness of primary care. Through its Practice Support Program, the province will develop and implement mental health and substance use training modules. It supports physicians in the application of new skills, practices and tools for the diagnosis, treatment and follow-up of adults and youth.

BC has also set out measurable indicators to assess progress on this training. These include:

- 800 family physicians and their teams will be trained by 2015 in mental health and/or substance use assessment and treatment modules
- by 2012, the number of physicians utilizing the Community Health Resource Directory will have increased to 1,000 – 50 percent more than the 500 users in the first half of 2010
- at least 60,000 British Columbians will have access to primary care mental health and substance use assessment and care plans by 2015.

The 2012 goal was surpassed. As of June 2012, more than 1,200 physician users were registered with the directory.

In addition to the general need for training, several jurisdictions noted in their mental health strategies that they face specific human resource issues. **Newfoundland and Labrador**, for example, cites as a challenge the retention and recruitment of well-trained professionals – notably

psychologists and occupational therapists – in core mental health disciplines. The province also faces program development challenges, including provincial skill mix guidelines for new initiatives, such as rural case management and crises services.

The team approach employed in *New Brunswick* will help ease access to specialized services in regions with relatively scarce resources. The province plans to employ teams to address the scarce resource issue and has committed to:

- revising guidelines for access to community mental health services to reflect the recovery model and include the role of families in treatment plans
- supporting regional health authorities in establishing mental health community advisory committees in all zones
- offering training to enhance mental health care capacity in primary care settings, integrating mental health care into primary health care delivery and enabling the proactive management of mental health stressors and illnesses
- establishing clinical protocols for tele-mental health videoconferencing units to enable the delivery of specialized services to rural areas
- providing funds for mobile crisis services to ensure their responsiveness to individuals' home communities and to avoid hospitalization.

Finally, it is of interest that most jurisdictions note their intention to employ evidence-based interventions. In *Newfoundland and Labrador*, for example, mental health and addictions services and programs will be based on current evidence and reflect best practices in the field.

One of the six goals of *Manitoba*'s strategy identifies the need to develop a provincial workforce strategy that assesses and guides recruitment, training and retention of the mental health services workforce; and to increase knowledge and use of recovery-based practices across systems. Specifically a need is identified to strengthen the peer support workforce.

*Alberta* will develop a competency-based mental health and addictions workforce with standardized roles and responsibilities. It plans to create attractive career choices and pathways for people who work in mental health and addictions. The province will implement best practices and standards across sectors to support the recovery and wellness approach, common assessment and intake, client experience measurement, case management and system navigation, peer and family support, and crisis response.

*BC* explicitly addresses the issue of evidence-based practices throughout its strategy, identifying them as key to the province's third goal of reducing the economic costs resulting from mental health and substance use problems. It plans to increase the capacity of clinicians to deliver evidence-based treatment services and will implement action plans for their delivery.

The *Northwest Territories* points to the need for routine and consistent collection of data to determine what is working effectively, what is not working and where improvements can be made.

## ***Challenge #2: Resources***

### *ii. Financial resources*

#### *The issue*

Limited financial resources represent a challenge not only in the mental health field. All human services, including child care, disability supports and affordable housing, face similar constraints.

Mental health treatment services involve highly qualified professionals. In addition to financing for human resources, all provinces and territories face significant expenditures related to the physical premises of mental health facilities and community supports. At the same time, many jurisdictions have announced enhancements to existing services and the introduction of new services.

#### *Opportunities for knowledge exchange*

The supporting evidence presented below illustrates the kinds of changes under way in the country. It is not meant to represent an exhaustive list. All the announcements regarding mental health programs and services are welcome enhancements. They are required in order to improve the quality of delivery and expand the quantity of available supports.

It is not clear, however, from the actual mental health strategies how the proposed new services will be financed. They will all need financial resources – whether in the form of new funds or a reallocation of existing expenditures.

In fact, the report of the Mental Health Commission *Changing Directions, Changing Lives* builds into its final recommendations that Canada must reverse many years of under-resourcing the mental health sector and making the system more efficient. In terms of funding, it should increase the proportion of health spending that is devoted to mental health from seven to nine percent over ten years [MHCC 2012: 127]. The announcements come at a time when most jurisdictions are facing deficits and grappling with tough fiscal circumstances.

While there is considerable discussion about new approaches and services, there is relatively little focus on their financing. How are officials making the case for these crucial investments in their respective jurisdictions? Are new methods of financing being tested by any province or territory? Are existing services or programs being curtailed or cancelled in order to proceed with new announcements?

Despite its gloomy deficit and cost-cutting measures, for example, New Brunswick's 2013 Budget commits to funding the continued roll-out of its mental health strategy. In Budget 2013, Newfoundland and Labrador maintained its commitment to open two new youth treatment centres and continued the planning for an adult addiction treatment centre and an adult mental health facility to replace the existing provincial psychiatric hospital. In the last three fiscal years, the province has

invested more than \$30 million in mental health and addictions services. In March 2013, Ontario announced that a new Mental Health Innovation Fund will invest \$27 million over three years to launch mental health projects aimed at postsecondary students. Nova Scotia has invested \$6,414,000 in its strategy since its launch in May 2012. It still is possible in tight fiscal circumstances to make crucial mental health investments.

### *Supporting evidence*

**New Brunswick** has designed initiatives to increase access to specialized services in underserved areas, including tele-mental health videoconferencing and mobile crisis services. Mental health community advisory committees in the province's seven zones will aid collaboration and information sharing. The Department of Health will offer training and support to enhance mental health care capacity in primary care settings, integrating mental health care into primary care delivery and permitting proactive management of mental health stressors and illnesses.

In 2012, **Nova Scotia** announced its intention to invest \$350,000 annually to expand the Strongest Families program across the province. It had won the Social Innovation Award from the Mental Health Commission of Canada, recognizing the program for delivering important economic and social benefits for children and families dealing with mental health problems. The 12-week, phone-based treatment program provides access to trained coaches who make available the tools, skills and support that families need to manage their children's mental health issues.

Nova Scotia has also developed several strategies to reduce wait times and build capacity. It has expanded its toll-free crisis line to ensure around-the-clock access and will be investigating the optimal location of acute psychiatric inpatient and withdrawal management beds. Raising awareness of problems, such as gambling addiction, and improving patient information-sharing guidelines helps build an informed and efficient mental health care system.

Wait times for mental health services is a recognized problem in **Ontario**. Plans to tackle this challenge include support for 600 new mental health workers across the province to help children, young people and their families gain access to effective mental health services and supports in schools, communities and courts. New resources include:

- 144 nurses based in schools to enable the early identification and treatment of students with potential mental health and/or addiction issues
- 260 new workers in community mental health agencies to provide youth access to services closer to home
- 21 new workers in the court system to keep youth out of the justice system and refer them instead to community-based services
- 175 additional new workers in schools who will provide support to young people to help address their mental health needs.

As a key objective, *Manitoba* seeks improved access to a range of services consistent with the principles of mental health recovery and the social determinants of health. It plans to:

- review current structures, policies and processes
- strengthen system capacity in six areas, including child and youth services as well as self-help and peer support
- improve service navigation
- ease access to services closer to home
- minimize access barriers for Aboriginals and new Canadians
- find ways to partner service delivery to First Nations communities.

Manitoba also intends to strengthen the integration of health, social services and related sectors. It will improve service pathways by collaborating with regional health authorities, the Selkirk Mental Health Centre and other organizations with a focus on transition points. The province will strengthen integrated service models and enable access to safe, affordable housing and services. It will support employment for persons living with mental health problems and use information technology to improve integrated health care.

*Alberta* has announced a wide range of strategies for strengthening and integrating mental health and addictions services. It will deliver mental health and addictions services at schools, universities, colleges, community agencies and long-term care homes. The province will enhance the capacity of peer supports and establish a single online portal with information on mental health and addiction services, self-care and peer support.

Alberta will also make available more clinic spots for individuals struggling with opioid dependency. They will receive replacement treatment through a team-based approach in areas of the province with the greatest need.

To deal with the issue of rural capacity and access, Alberta's strategy calls for the province to undertake rural community capacity building and to improve access to provincial addiction and mental health services. The province will improve the use of technology to deliver mental health services and create rural mobile outreach teams. Ultimately, a new transportation policy and plan will enable the delivery of mental health services to rural communities.

To shorten wait times, Alberta will introduce new ways to provide care. One example is the quick-referral Choice and Partnership Approach, which includes a first visit for individuals and families shortly after they have been referred. Patients get into treatment sooner and are matched with the clinician who has the expertise to best meet their needs. The province is also working on the premise that a focus on early intervention, through innovative approaches and mental health professionals in schools, will create a more responsive mental health care system.

When fully implemented, *Nunavut's* suicide prevention will make available a wide range of community mental health and addiction resources. Strategies include providing enhanced training to mental health specialists in each region and more training for community-based counsellors.

## ***Challenge #2: Resources***

### *iii. Relative distribution among components of the system*

#### *The issue*

While the mental health strategies throughout the country focus largely on treatment, they all make reference to the need for improving the quantity and quality of community services. Community-based services fulfill two main purposes: They help prevent the onset of serious mental illness and they ensure the provision of high-quality care and support after treatment.

Selected examples from both streams of community-based work are presented below. These derive directly from the various mental health strategies as well as a review of community-based initiatives introduced by provinces and territories over the past year. Provincial and territorial efforts in related fields are summarized in Appendix B.

#### *Opportunities for knowledge exchange*

A number of challenges arise from the community-based work within the various mental health strategies. The first stream involves building healthy communities in order to promote health and well-being, and to prevent mental illness.

The second stream, as noted, entails the availability of community supports to assist persons with mental illness live independently. This dimension includes a range of affordable housing options and other individualized personal assistance, which is often embedded in the housing arrangement.

Preventive interventions comprise an essential component of the broader mental health field. The challenge arises from the fact that this activity consists of many different interventions which relate to, but are not typically situated in, mental health. Preventive measures involve initiatives related to cultural expression, recreation, youth engagement, family support, community-building events and other areas that are not billed as mental health *per se* but that contribute immeasurably to positive well-being.

It is not clear if and how the mental health strategies link to these other areas. Most of these interventions are housed in departments outside the one primarily responsible for the mental health strategy in that jurisdiction. Many are initiated by local governments and the voluntary sector. How do provinces and territories ensure that their community building initiatives, which contribute significantly to good mental health, capture and relate to efforts that are outside the core department and even external to government?

The positive note is that several jurisdictions are providing support to voluntary organizations to carry out much of this mental health promotion activity. But there are questions as to whether the community-building efforts to which the mental health frameworks refer are actually part of a broader

strategy. This work may simply take the form of short-term grant funding rather than an explicitly coordinated effort in which the many constituent parts work strategically and coherently toward a common goal.

The second stream of work involves the building of community services to enable independent living. All the mental health strategies acknowledge that this is a crucial part of the equation and several jurisdictions have noted their intent to bolster this component of the mental health continuum.

But like other areas of human service, community-based supports typically receive only a fraction of funding relative to treatment services, even though the former play an invaluable preventive and supportive role in the spectrum of mental health interventions. A discussion about a better weighting of treatment relative to community investments would be welcome.

There are several dimensions to this conversation, including how to make the case for more investment at the community level. It would also be important to consider new forms of funding, such as social finance arrangements, and to explore their respective strengths and weaknesses in potentially supporting community-based mental health services.

One recent piece of positive news was announced in federal Budget 2013, which signalled its intent to renew the Affordable Housing Agreements when these expire in 2014. The Agreements are renewed for five years at current funding of \$253 million per year. This investment will help alleviate housing need by funding the provision, construction and repair of affordable housing. A commitment to social housing at the federal level will help bring some stability to this field, which is a vital component of mental health supports.

Another important announcement in the 2013 federal Budget was the renewal for five years at \$119 million per year of the *Homelessness Partnering Strategy*. The funds are being targeted toward a Housing First approach. These monies will continue to build on the lessons of the Mental Health Commission of Canada's At Home/*Chez Soi* project, a five-year initiative which provided 2,000 individuals in five cities with housing and support services tailored to their needs.

The distribution of resources between mental health treatment services and community supports is one side of the equation. The other is the distribution of resources among groups in the population. The large number of Canadians who will become seniors within the next two decades will require a proportionately larger share of health care spending. As more resources are directed toward seniors' health care and the treatment of Alzheimer's and other mental health-related dementias, what actions must be taken to ensure that sufficient funds are also directed toward youth?

### *Supporting evidence*

The *Newfoundland and Labrador* framework acknowledges that mental health services belong primarily in the communities where people live. It also points to the importance of family

caregivers, self-help support groups and community activities such as churches, social and recreation groups.

While focused mainly on one component of the Community Resource Base Model – the mental health and addictions system – the framework is designed to work in harmony with the other elements. A Ministerial Advisory Council for Mental Health and Addictions was established in 2010. This council, composed mainly of community groups and those with lived or family experience of the mental health and addictions system, advises the Minister on key mental health and addiction policy matters.

*New Brunswick's 2010 Hope is a Home* housing strategy is a five-year bricks and mortar plan to reduce poverty by making housing more affordable. Two youth-focused programs in Saint John – one aimed at homeless youth, another at teenage parents at risk of homelessness – have recently been awarded funding. Safe Harbour Transitional Youth Services, a planned housing facility for homeless and at-risk youth ages 16 to 24, will become part of a coordinated effort to provide housing and support services to the nearly 200 homeless youth in the Greater Saint John area.

The First Steps Housing Project Inc. in Saint John will use federal funding to gain a better understanding of the effectiveness of its youth homelessness program. First Steps provides assistance to pregnant or parenting young women and their children who are homeless or at-risk of homelessness. Funds will be used to assess the social and financial benefits of their youth homelessness program using a framework that First Steps developed.

One of *Nova Scotia's* major objectives is to enhance community-based capacity and services. It commits to enhancing the quality of life for clients, patients and families by bolstering the capacity of community-based addiction and mental health services, and by improving the effectiveness of specialized and in-patient care. It will offer skills-based interventions to families that need help through the family-inclusive Meriden Family Work Program and the addictions-focused Community Reinforcement and Family Training program.

An expanded Peer Support program will be phased in across Nova Scotia to provide ongoing assistance for people in transition from a hospital who require peer support to live successfully in the community. The province has also invested in school-based efforts to promote mental health and prevent mental illness among children and families.

*Ontario* is building school-based capacity to identify mental health problems at earlier stages. It will implement mental health literacy and cross-sectoral training on early identification and intervention for educators. The province will also create local hubs for activities and services by incorporating mental health and addictions programs in community locations that can be easily accessed.

*Manitoba* will seek to enhance family participation. It will strengthen resources for families and informal supports, including a plan to remove barriers and help navigate the service system.

Another key goal is to ensure that all residents receive recovery-oriented services as close to home as possible.

The first of *Alberta*'s five priorities involves the building of healthy and resilient communities. Key actions include creating environments that build protective factors for health, mental well-being and resilience, and that reduce risk factors contributing to addiction and mental health problems.

More specifically, six areas of focus will help the province achieve healthier communities:

- early childhood, maternal and family health
- healthy and resilient schools
- building capacity and resilience in populations at risk
- business partnerships
- healthy living environments for older adults
- public acceptance and understanding.

*British Columbia* has stated its intention to strengthen residential treatment options by enhancing access to evidence-based community placements and residential therapeutic options for children and youth with mental disorders. By 2015, residential redesign will result in a greater range of out-of-home care options to meet the needs of children and youth with mental health and/or substance use problems.

### ***Challenge #3: Governance and Accountability***

#### *i. Collaboration and coordination*

##### *The issue*

Multiple interventions are required to tackle all the dimensions of mental health in terms of both prevention and treatment. The wide-ranging mental health strategies, despite their differences, have an important element in common. They all consist of an array of programs and services run by different ministries and departments within a given jurisdiction. Voluntary organizations also play a major role in both service delivery and health promotion.

##### *Opportunities for knowledge exchange*

The involvement of a number of players requires a coordinated approach among diverse departments and organizations to ensure that the multiple parts of the system – both within and outside government – work well together. While all the mental health strategies are led by and housed within a specific government ministry, there is acknowledgment of the need for concerted action among all parts of the system including social services and housing, education, child welfare and justice.

In fact, most provinces and territories recognize the need for a joined-up approach and have proposed various ways to effect this coordination. The extent to which this objective is working well in practice is unknown, given current reporting requirements that typically involve ‘vertical’ accountability up and down the chain rather than ‘horizontal’ accountability through joint initiatives.

A major question has to do with how jurisdictions know that their continuum of services is well coordinated in practice. Are they asking for feedback from individuals and their families with direct experience in the mental health care system? How do provinces and territories ascertain that the multiple components of their mental health systems are actually lining up a coordinated way? From whose perspective is effective collaboration being assessed?

Knowledge exchange around all these questions may enhance the ability to respond to the coordination challenge. It also enables provincial/territorial capacity to jointly monitor progress and assess the impact of diverse mental health interventions – another component of the governance and accountability challenge, discussed below.

##### *Supporting evidence*

***Newfoundland and Labrador*** notes that strong program connections among all components of the mental health and addictions system, the broader health system and the community will enable the provision of timely and appropriate services. Priority problems include service fragmentation, not putting the patient first and failure to respond to the changing clinical needs of the population.

The provincial strategy commits to the collaborative design, development and delivery of mental health and addiction services. The creation of four Regional Integrated Health Authorities placed responsibility for the full range of mental health and addictions programming under a regional director in each authority and provided a strong foundation for implementing a coordinated approach.

Partnerships have been strengthened among mental health and addictions organizations such as the Canadian Mental Health Association, the Consumer Health Awareness Network of Newfoundland and Labrador (CHANNAL), the Eating Disorders Foundation of Newfoundland and Labrador, Schizophrenia Society of Newfoundland and Labrador and other local groups. Since 2010, more than \$1.8 million has been provided to more than 13 community agencies to strengthen community capacity and partnerships.

*Nova Scotia* also calls for collaboration among its various interventions. As part of its goal to ensure safe and affordable housing options for Nova Scotians with mental health and addiction problems, the mental health strategy notes the need for improved collaboration between the Department of Community Services and the Department of Health and Wellness. The government states its intention to work with municipalities to tackle the consequences of alcohol harms through targeted grants.

A priority objective in *New Brunswick* is to better align efforts to deliver seamless services by placing the person living with mental illness at the centre of treatment and care. In respect of this objective, the province will establish a deputy ministerial committee representing all relevant government departments to provide oversight in the implementation of this action plan. New Brunswick will also implement a common consent form for the disclosure of personal information of individuals living with a mental health problem to enable interdepartmental case management.

The engagement of partners in all aspects of health care delivery is another key dimension of the New Brunswick mental health strategy. This approach will encourage more collaboration among partners to reduce fragmentation and enhance social inclusion. The efforts will help address gaps in education, employment, income, housing and the criminalization of mental illness.

More specifically, community treatment teams will be created in seven zones across the province to provide recovery-based community interventions to persons experiencing serious mental illness. The teams will include peer support and ensure the provision of housing, employment and treatment.

*Ontario* has established an interministerial Assistant Deputy Minister's Committee involving four primary ministries (Ministries of Health and Long-Term Care; Education; Children and Youth Services; Training, Colleges and Universities) and two secondary ministries (Ministries of the Attorney General; Community Safety and Correctional Services) to oversee the first three years of the Strategy. The interministerial Assistant Deputy Minister's Committee reports to the Deputy Minister's Social Policy Committee as needed.

Ontario's approach to governance has evolved to meet the unique needs of its population. Time-limited expert working groups and reference panels have been implemented to provide advice and expertise which best meet the needs of the people of Ontario. For example, the Minister's Expert Working Group on Narcotic Addictions was convened to provide short-, medium- and long-term advice on responding to the change from OxyContin to OxyNEO and strengthening Ontario's addiction treatment system as part of the comprehensive mental health and addiction strategy. The Expert Working Group had broad representation from clinicians, front-line workers, clinic directors, addictions experts and people with lived experience of narcotic addiction.

In 2007, *Manitoba* had established the Cross-Department Coordination Initiatives Division to coordinate the joint activities of Family Services and Consumer Affairs, and Manitoba Health. The Division works in partnership with regional health authorities and communities to integrate service provision, improve collaboration, and coordinate strategies in housing and supports for seniors and individuals with homelessness and mental health issues.

The province's mental health strategy also identifies "shared responsibility" as one of its six pillars where it commits to calling all components of the service system, the community and government to action to take deliberate action to work together to strengthen policy, program and practice regarding mental health.

*Alberta's* mental health strategy *Creating Connections* recognizes the interdependence among primary health care, community-based services and in-patient beds. Its development was led by Alberta Health and Wellness and Alberta Health Services.

The Alberta strategy involves 16 ministries, in recognition of the fact that people with addiction and mental health issues typically are served by many government departments. The strategy's completion followed three years of service consolidation during which a single health authority was created by amalgamating the province's nine regional health authorities, Alberta Mental Health Board, Alberta Alcohol and Drug Abuse Commission and Alberta Cancer Board.

To achieve the wide-ranging goals identified in its mental health strategy, BC notes the need for collaborative action – from individuals and community organizations to local and provincial government leaders. But collaboration does not just happen on its own without a designated unifying mechanism. BC is working within a Whole Systems Approach by involving all partners when making decisions for planning, developing and implementing high-quality prevention and care services.

The strategy acknowledges the importance of a governance structure with performance monitoring capability in order to initiate and sustain systemic change. To that end, *BC* has put in place a performance accountability team under a lead Deputy Minister to further ensure a government-wide and systems-wide approach. The team will work with all relevant ministries as well as other partner organizations and key stakeholders, including individuals living with mental health or substance use problems.

In *Nunavut*, the Department of Health will play the central role in mobilizing other departments including Family Services, Education, Justice, and Culture and Heritage to ensure that they are all committed to implementing the Territory's Suicide Prevention Strategy. The strategy resulted from a partnership among Nunavut Tunngavik Inc., Embrace Life Council and the Royal Canadian Mounted Police. Collaboration and partnership are central to the territory's mental health program planning and operations.

The mental health plan in the *Northwest Territories* seeks to encourage departments and agencies to work collaboratively to address mental health and addictions issues. The plan will build upon the existing Integrated Services Delivery Model. Services will be coordinated to enable front-line service providers to work together. A seamless system will be created through the integration of community, regional and territorial services – although it acknowledges that some specialized services are delivered more efficiently at the regional or territorial level.

### ***Challenge #3: Governance and Accountability***

#### *ii. Monitoring and assessment*

##### *The issue*

Monitoring and assessment are key challenges in all domains of public policy. These functions are not unique to mental health.

##### *Opportunities for knowledge exchange*

While monitoring and assessment of core interventions are essential, these tasks may be more difficult to carry out in mental health, in particular, because of the nature of the domain itself. It may be tough to assess actual changes in an individual's or a family's mental health. Equally complex is the fact that the results of a given action may not become apparent for many months or even years, making it difficult to attribute the observed result(s) to a given intervention.

Another challenge involves assessing the impact of mental health promotion – whose purpose is to prevent the occurrence of mental illness in the first place. It is hard to collect quantifiable evidence of something that presumably was avoided.

The diverse mental health strategies throughout the country point to many different approaches to monitoring and assessment. Some provinces and territories have chosen to identify desired policy goals and objectives rather than select explicit or even numeric targets. Other jurisdictions, by contrast, have articulated specific goals along with associated indicators by which to gauge progress.

The work under way on all the provincial and territorial mental health strategies leaves the door open to considerable opportunity for the exchange of effective assessment practices. There is a need for informed conversation on successful evaluation methodologies and practicable indicators of progress. What measures have been found to be particularly valuable indicators? Are there indicators that appear to be missing and require development?

Moreover, there are questions as to whether developments in the broader context have made more difficult the various provincial and territorial efforts to reduce stigma. Has the media focus on high-profile criminal cases involving mental illness, for example, made it harder to create a receptive environment in the general public for mental health? Is there any value in working with the media to discourage sensational reporting and focus instead on positive models of successful mental health initiatives?

##### *Supporting evidence*

***Nova Scotia*** is one jurisdiction that sets out general goals for monitoring and assessing progress on its mental health strategy. Rather than set numeric targets, its framework puts forward general goal statements:

The strategy is focused on health promotion, early intervention, closing gaps in the system, improved cultural and other competencies, peer and community supports, and reducing stigma through greater public awareness. It is based on our current understanding of what works, and what will have a significant impact and can be accomplished within the context of declining resources and competing needs [Nova Scotia 2012: 1].

While the document gives assurance of regular monitoring and evaluation, no details are provided as to how these functions will be carried out. Among its suggested indicators are:

- broadened understanding of mental illness and addictions issues
- greater community involvement in the issue
- doing things differently
- working together with a shared vision
- better information to guide decisions.

In order to show accountability and measure progress toward its goals, *Newfoundland and Labrador* will set out relevant indicators regarding quality mental health, addictions services and population mental health status. It will work toward the implementation of a provincial indicator framework to assess progress and provide results for public release.

*Manitoba* makes similar reference to building on evidence. Its plan calls for continuing action to strengthen the knowledge of “what works.” The province will seek to continually improve evaluation capacity in order to identify leading and promising practices, and to exchange this knowledge among those involved in mental health.

Rather than setting specific targets, Manitoba will establish an experts group to develop a work plan for each of its six major goals. These will be organized through a coordinating body that will be accountable to a departmental steering committee. A five-year work plan will result.

Working groups will identify specific, valid and measurable outputs and outcomes, based on the strategic actions in each goal area. A corresponding evaluation plan will measure the strategy’s success on several levels including practice, program, organizational and policy. The evaluation framework will translate the strategic plan into measurable actions.

The *Nunavut* plan commits the Implementation Committee, consisting of all involved partners, to evaluate and monitor on an ongoing basis the implementation of the *Suicide Prevention Strategy*’s goals and objectives. The purpose of this regular monitoring is to ensure continuing momentum and accountability by all Committee members toward achieving the vision set out in that framework.

The *Northwest Territories* strategy focuses not so much on new mental health interventions but rather on the expansion of existing programs into new regions. Best practice lessons will be shared among delivery agents, government and community representatives. No specific assessment details are provided. Rather, the framework notes the need for research to help design an accountability framework, clarify roles and responsibilities, and devise a performance measurement strategy and evaluation plan.

In contrast to these general plans, several jurisdictions identify specific targets to be achieved. *New Brunswick*'s mental health strategy sets out seven goal areas with 12 targets, 11 of which are expressed in numeric terms. It will create an interdepartmental case management process to ensure continuity of service to all persons living with mental illness.

More specifically, the strategy will seek to increase the number of youth who benefit from the timely, effective and coordinated approach delivered through an integrated service delivery model – with a goal of 400 youth by 2014. The sole non-numeric target under its second goal of realizing potential through an individualized approach will use a survey to “reveal positive changes in the attitudes, practices and skills of the staff.”

Each year, *Quebec*'s ministry of health and social services enters into a contract with the various regional health authorities (*agences de la santé et des services sociaux*). Contracts include service targets that each authority must reach, as determined by ministerial priorities. Targets are set for primary mental health services and for Assertive Community Treatment Services [*Gouvernement du Québec* 2012]. Quebec is a leader in fighting the stigma associated with mental illness, operating an annual anti-stigma media campaign since 2008.

*Ontario*'s Ministry of Health and Long-Term Care is working with the Institute for Clinical Evaluative Sciences (ICES) to develop a scorecard and evaluation framework to report on the success of the strategy. ICES is working with all the ministries to develop a new database that will enable linkage of data across the various sectors (e.g., children and youth mental health, education, youth justice, health services). The scorecard is expected to be populated by the end of March 2014 and a public report is planned.

The strategy's objective of creating healthy, resilient and inclusive communities will be assessed through:

- less stigma and discrimination in public services and in the workplace
- additional community supports for people with lived experience and their families
- more people with mental health and/or addictions issues employed and integrated in their communities
- more people living in safe, stable homes and fewer living in shelters or hospitals.

The early identification of and intervention in mental health and addictions problems will be measured by increased numbers of Ontario youth graduating from high school and moving to post-secondary education. More Ontarians with mental health and addictions problems will be identified early and receive appropriate services and supports.

The goal of providing timely, high-quality, integrated, person-directed health and other human services will be assessed through shorter wait times for community and hospital-based services; fewer repeat emergency department visits and unplanned hospital readmissions; more appropriate service linkages and referrals from the justice system; lower per person cost of mental health and addictions services; and indicators – better mental health outcomes and improved quality of life.

Given Ontario's preliminary focus on children and youth, it is not surprising that the evaluation of that component of the mental health strategy is more clearly defined, with identified numeric targets. These include but are not limited to:

- 9,000 more children and youth will benefit from the addition of mental health workers in schools
- 16,000 youth with mental health needs will be supported at the transition from secondary to post-secondary educational settings
- 13,000 more children will receive direct treatment services through a targeted funding increase to community-based child and youth mental health agencies.

**British Columbia** is also pursuing the quantifiable route by identifying a set of milestones as success indicators as part of *Healthy Minds, Healthy People*. An early task of the accountability team in BC will be to align necessary internal resources to support performance monitoring and formulate mechanisms to ensure achievement of the Plan's milestones, priorities and actions. It will build on existing structures and agreements, such as service plans.

Performance measures will continue to be refined in order to monitor implementation. BC will develop instruments and responsibilities for data collection, analysis and reporting. While more of these milestones are to be formulated with key partners, some preliminary ones have already been identified. They include, but are not limited, to the following:

- The number of British Columbians who experience positive mental health will increase by 10 percent by 2018. (In 2008, 68 percent of residents reported they experienced positive mental health. Source: Statistics Canada.)
- The number of young children who are vulnerable in terms of social-emotional development will decrease by 15 percent by 2015. (In 2008, 13 percent of kindergarten children demonstrated vulnerability related to social competence and 12 percent demonstrated vulnerability related to emotional maturity. Source: Early Development Instrument, Offord Centre for Child Studies, McMaster University.)
- By 2014, 10 percent fewer students will first use alcohol or cannabis before age 15. (In 2008, of all students who reported ever drinking alcohol, 75 percent first tried it before age 15. Of students who reported ever using cannabis, 67 percent first tried it before age 15. Source: McCreary Centre's BC Adolescent Health Survey.)

The goal of enhancing the capacity of community-based mental health and substance use services will also be guided by a clear set of actions and associated indicators. In terms of commitments to BC's children and youth, indicators of success include, but are not limited to, the following:

- By 2015, 15 percent more young children will be routinely screened for healthy social and emotional development using the Ages and Stages Questionnaire: Social Emotional.

- By 2011, universal developmental outcomes will be measured for children receiving services through the Ministry of Children and Family Development.
- By 2013, health authorities and key partners will use a cross-sector framework for planning, and children and families with parents who experience mental health and/or substance use problems will have access to services and supports.

### ***Challenge #3: Governance and Accountability***

#### *iii. Receptive environment*

##### *The issue*

Perhaps the most daunting challenge is the creation of a more receptive environment for mental health – both for people living with mental illness and for policy interventions and investments in this area. Most of the work with respect to individuals entails some form of public awareness effort or campaign to reduce the stigma around mental illness. Making the case for policy intervention or public investment typically involves the use of relevant data on the cost of mental health problems and the failure to intervene effectively both before and after the fact.

##### *Opportunities for knowledge exchange*

When it comes to creating a receptive environment for mental health, there are several areas in which knowledge exchange would be helpful. Jurisdictions engaged in efforts to reduce stigma can identify the messages that appear to resonate with the public and the approaches that seem to have been less successful. They can also share information on the methods they have used to assess or even measure reduced stigma. BC's strategy states, for example, that it will tie into the Mental Health Commission's national anti-stigma initiative.

Similarly, provinces and territories that have employed caseload and cost-benefit data can report on the types of arguments that have led to increased investment in mental health treatment services and community-based supports. There potentially could be a valuable pan-Canadian conversation about the data and evidence that were particularly effective in making the case for this investment and how best to present these arguments. It would be helpful to know whether it is felt that additional cost-benefit analyses and arguments are required in order to bolster arguments for investing in mental health.

Over the last few years, emerging networks and hub websites have enabled knowledge exchange, pulling together and collecting in one place all the valuable literature references and data sources in a given area. In 2009, the Mental Health Commission of Canada announced plans to develop a knowledge exchange centre – a web resource to house evidence-based information on mental health and mental illness. While the information and knowledge are available, it is not clear whether they are being effectively shared or applied.

##### *Supporting evidence*

At the individual level, several jurisdictions set out clear objectives and intended actions to reduce stigma. ***Newfoundland and Labrador***, for example, will initiate a multi-year, multi-media awareness campaign within the next year. Informed by a community leadership committee composed of individuals and families with lived experience, the goals of the campaign are to decrease stigma and

discrimination and enhance access to effective, evidence-based services for people with experiences of mental illness and addiction. The campaign will target the public, health care providers and youth.

This program is grounded in strong partnerships, stakeholder engagement, evidence-based practice and the following multifaceted comprehensive model which includes:

- program rooted in stakeholder engagement, monitoring and evaluation
- support for anti-stigma grassroots initiatives at the community level
- public relations and communications that raise the profile of mental illness and addiction issues
- literacy training and education for health care professionals and the public
- interactive web-based support services that create greater access to new and existing mental illness and addiction services
- public anti-stigma and discrimination awareness campaign
- linkage and knowledge exchange web portal to coordinate efforts among mental illness and addiction stakeholders.

*New Brunswick* identifies knowledge enhancement as an explicit goal along with the following commitments:

- inform those living with mental illness, their families and other significant individuals about mental illness, the recovery model and mental health promotion
- enhance the knowledge of health care providers by introducing curriculum on mental health promotion, anti-stigma, the recovery method, collaborative models of care, culturally competent and safe services in academic institutions, and the provision of compulsory ongoing training under clinical supervision
- improve the knowledge of health care providers by supporting mental health care research
- enhance the knowledge of government and other service providers through education and on-the-job training on mental health issues
- implement an effective recruitment and retention strategy for mental health care professionals.

New Brunswick includes an additional goal of reducing stigma by enhancing awareness. To achieve this objective, it makes the following commitments:

- promote respect and acceptance by initiating anti-stigma initiatives to target the public and the health care sector
- reduce stigma and promote inclusion in educational, workplace and community settings
- improve the mental health of the population
- identify successful mental health promotion and prevention initiatives, and introduce or expand upon these programs throughout the province
- increase mental fitness in the population by implementing elements of New Brunswick's Wellness Strategy in partnership with the lead Department of Wellness, Culture and Sport, and government and nongovernmental partners.

*Nova Scotia* pledges to deliver anti-stigma initiatives with a proven track record. People dealing with mental illness and addictions who want to share their story will be supported and heard. The province will distribute to the media the reporting guidelines developed by the Canadian Psychiatric Association and engage them in discussions on the use of respectful language.

Nova Scotia also plans a suite of employment-related initiatives. It will raise public awareness about the importance of psychological health and safety in the workplace. The province will seek to improve employers' knowledge of programs for addressing mental health and addictions issues.

*Ontario* is another jurisdiction that identifies reducing stigma and discrimination as a major goal. It plans to implement more mental health promotion and anti-stigma practices for children and youth, educators, health providers, workplaces, seniors' service providers, municipal service providers, justice providers and the public.

In October 2011, *Alberta* introduced the Lieutenant Governor's Circle on Mental Health and Addiction comprising experts in the field, community leaders and persons with lived experience of addiction and mental health problems. Its mandate is to reduce stigma related to mental illness and addiction, enhance public knowledge of the topic, encourage positive steps being taken to improve the lives of individuals affected by mental illness, and promote collaboration among organizations and initiatives that deal with mental health and addiction.

In 2013, the Lieutenant Governor's Circle on Mental Health and Addiction in Alberta will inaugurate its True Awards. These will celebrate individuals and organizations leading the way in work to deliver mental health programs and services, reduce stigma and encourage recovery.

The mental health framework in the *Northwest Territories* will promote understanding, awareness and acceptance by tackling issues such as housing, income support and education. It will acknowledge the impact of colonization, residential schools and rapid socioeconomic change. The Territory will also highlight positive models of resiliency and healthy communities by regularly collecting and sharing data, success stories and areas for improvement.

In terms of making the case for policy commitments and financial investments, several provinces and territories refer explicitly to the high and rising costs of mental health-related problems.

*Quebec*'s initial mental health action plan (2005-10) highlighted the realities facing the population and the mental health care system. Mental health problems affected one person in every six and suicide rates were very high. Quebec also faced serious problems around accessibility to and continuity of mental health services.

In *Manitoba*, growing health care costs and a national and global movement toward addressing mental health issues comprise the foundation of the provincial strategy.

In 2003, the incremental cost of mental illness in Canada was an estimated \$51 billion, with close to 30 percent of the cost related to undiagnosed mental health problems and related illnesses. In Manitoba, in 2007-08, expenditures were more than \$400 million for services that

addressed mental health (including hospital and community-based services, income assistance, federal disability). This figure does not include the economic costs to other systems such as the justice system, schools, workplaces, families, private insurance companies and other social service systems that support people with mental health problems and illnesses. Nor does it put a price on the emotional suffering and quality of life lost for people experiencing mental health problems and illnesses, their families and other supports, and their communities [Manitoba 2011: 5].

**Alberta's** mental health strategy employs Health Canada data to argue that 20 percent of people experience a mental illness in their lifetime, and everyone has a friend, family member or colleague who has been or will be affected. It cites figures from the Centre for Addiction and Mental Health that 10 percent of people over age 15 may be dependent on alcohol or drugs [Statistics Canada 2003]. Some are experiencing both mental disorders and substance abuse problems [Rush et al. 2008].

Alberta also notes that while the economic cost of mental illness comprises more than 15 percent of the burden of disease in Canada, these illnesses receive only 5.5 to 7.3 percent of health care dollars [Institute for Health Economics 2008]. In light of these figures, the province states that addiction, mental health problems and mental illness can be mitigated and treated cost-effectively if promotion, prevention and treatment are based on informed practice provided in the most cost-effective setting and delivered in a timely manner.

**BC** has identified as an explicit goal the need to reduce the economic costs to the public and private sectors resulting from mental health and substance use problems. It presents both cost figures and cost-benefit data. The BC Ministry of Child and Family Development spends about \$94 million a year to tackle child and youth mental health and substance use challenges. About 75 percent of those funds – \$70 million – is allocated to community-based mental health services.

The remaining monies are directed toward specialized services, mental health services for youth involved in the justice system or in custody, and substance use treatment in the youth justice system. An estimated 20,000 children and youth receive community mental health services annually – more than double the number in 2003. These services are provided by about 500 mental health practitioners employed by the ministry and through contracts with approximately 130 agencies.

The BC mental health strategy presents cost-benefit data to justify this investment. The document cites a Canadian study which suggests that mental illness costs the Canadian economy about \$51 billion annually in lost productivity [Smetanin et al. 2011]. BC's proportional share of that burden would be more than \$6.6 billion each year. The indirect costs of lost productivity related to alcohol use alone are estimated at \$1.1 billion.

The Smetanin et al. study was conducted on behalf of the Mental Health Commission of Canada. In its 2012 report, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, the Commission cites further evidence from the study to help make the case for investment in mental health.

1 in 5 Canadians are affected annually by mood disorders, anxiety disorders, schizophrenia, attention deficit/hyperactive disorders (ADHD), conduct disorders, oppositional defiant disorders (ODD), substance use disorders or dementia. Not only does mental illness impact individuals but it also places a significant impact on families, communities and the health care system. In 2011, this study conservatively estimated that the cost of mental illness was \$42.3 billion in direct costs and \$6.3 billion in indirect costs. Over the next 30 years, the life and economic consequences of mental illness are expected to be magnified due to the increase in the expected number of people living with mental illness as a result of the aging and growth of Canada's population over the next 30 years. Within a generation, it is estimated that more than 8.9 million Canadians will be living in a mental illness [Smetanin et al. 2011].

The Commission points out that “unlike for other health conditions, only one in three people who experience a mental health problem or illness – and as few as one in four children or youth – report that they have sought and received services and treatment” [MHCC 2012: 9]. This data speaks powerfully to the need for concerted efforts to reduce stigma and invest in mental health treatment.

A 2010 study commissioned by the Mental Health Commission of Canada helped fill in knowledge gaps regarding the number of people living with mental health issues and the associated costs. Among young adults, the study confirmed that more than 28 percent of people ages 20 to 29 experience a mental illness in a given year. By the time these individuals turn 40, half of them will have had or have a mental illness. When family members and caregivers are included, virtually all Canadians will be affected by mental health problems and illnesses [MCHH 2013].

The study also maintains that if the mental health care system can reduce the number of people experiencing a new mental illness by 10 percent in a given year, Canada will save \$4 billion a year after 10 years. The authors conclude that their evidence offers three compelling reasons for Canada to invest more in the Commission's mental health strategy: “The needs are substantial and will continue to remain substantial over the coming 30 years; current costs are very high; and, while some costs are necessary and cannot be avoided, not acting on the strong evidence for what works will cost even more” [MHCC 2013].

## *Future trends in mental health treatment and service management*

The preceding discussion makes clear the many possible areas for knowledge exchange. It also raises questions about future trends in both mental health treatment and management.

In the area of treatment, there are some significant developments on the horizon. The earlier discussion made reference to the emerging focus on consumer-directed care, also known as “activation.” Questions are arising about the future application of this principle in practice. For example, there does not appear to be an associated reallocation of financing, through such methods as individualized funding, to reflect this shift in orientation.

Conversations are also under way in the mental health field regarding the movement away from a disease-based focus to symptom-based treatment. The Centre for Addiction and Mental Health, for instance, is dispensing with the notion of disease and heading more toward treatment of the population in a holistic way.

This development represents a profound shift in orientation. It means that individuals would receive treatment on the basis of the symptoms they present rather than the diagnoses they are ascribed. This shift would help address many of the problems earlier identified, such as the challenges associated with complex disorders. Precise diagnoses would become less important than alleviation of presenting symptoms.

Movement toward holistic treatment of the person necessarily involves a team approach. New paradigms will require the joined-up collaborative processes toward which provinces and territories are already moving.

Technology is another development that will have a major impact on the provision of mental health treatment and services. Electronic personal health records will allow faster, more accurate transfer of information – and ideally fewer complications associated with medication interactions. As in other fields, however, technological developments give rise to privacy concerns and the protection of personal information that need to be addressed.

New technologies are also opening up possibilities in rural and remote communities for the early identification and treatment of mental health problems. Electronic communications are allowing the provision of networks of support at home and are enabling independent living in communities. As in other fields, there are lags in the ability of the mental health system to keep abreast of all the technological advances. New applications are being developed that have not yet even made their way into mental health vocabulary – let alone practice. There is a need for training to identify technologies that might be appropriate and how best to use them.

Finally, several issues must be considered in future around the management of mental health treatment and supports. Provinces and territories will continue to refine their accountability processes. But there are other reporting mechanisms on the horizon that will need to be taken into account.

BC's 2012 mental health report card, for example, shows movement toward clearly defined goals as well as evidence of how early targets can influence and shape future system improvements. The 2012 launch of the Healthy Start program in that province includes screening for perinatal depression. Next steps include supporting public health practitioners to provide consistent quality services and adopting a new screening tool for depression.

A similar evaluative effort emerged from the Ontario mental health strategy's three-year focus on children and youth. One of its priority initiatives was to develop a baseline scorecard that describes the current state of the child and youth mental health system throughout the province. This work is being undertaken by the Institute of Clinical Evaluative Services and the release of the scorecard is expected in the near future.

Finally, there are many questions about the future role of research – both its placement and its application into practice. *Alberta Innovates*, for instance, offers exciting opportunities to embed research into government operations. While evidence-based research is a focus of many of the existing mental health strategies, there traditionally has been an arms-length relationship between research and government. Alberta represents a new way of integrating ideas and action by incorporating *Alberta Innovates* within government itself. Its internal placement may help expedite the process of research translation.

New Brunswick announced in April 2013 that its new Research and Innovation Council will guide research and innovation across all sectors and stakeholders. One of its *ex-officio* members is the chair of the New Brunswick Health Research Foundation. Knowledge exchange bodies, such as the Ontario Centre of Excellence for Child and Youth Mental Health, offer a model of the kind of information hub that is critical for tracking and advancing evidence-informed practice and evaluation of outcomes.

## *Conclusion*

Mental health has finally arrived as a significant issue on the public agenda. The various provincial and territorial mental health strategies that have been introduced or are being prepared are a testament to the wide-ranging efforts currently under way throughout the country.

While these strategies are diverse, they are all bound by common philosophical and conceptual underpinnings. In their own unique ways, all jurisdictions seek to achieve similar objectives: promote positive mental health, bolster the quality and quantity of services, and ensure that individuals living with mental illness can participate fully in the community.

Taken together, the provincial/territorial strategies represent a vast array of interventions. Some are extensions of work already under way and other efforts are entirely new approaches.

Either way, there is substantial potential for sharing methods and lessons that have been learned in the course of this work. The current state of mental health in Canada presents significant opportunities for knowledge exchange to help enhance the quality of services, apply important lessons and ensure the strategic use of human and financial resources – all in aid of creating a more receptive environment for mental health.

## References

- Gouvernement du Québec. (2012). *Rapport annuel de gestion du ministère de la santé et des services sociaux, 2011-12*.  
<http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2012/12-102-01F.pdf>
- Institute for Health Economics. (2008). *How Much Should We Spend on Mental Health?*  
<http://www.ihe.ca/documents/Spending%20on%20Mental%20Health%20Final.pdf>
- Joshi, P., D. Damstrom-Albach, I. Ross and C. Hummel. (2009). *Strengthening the Safety Net: A Report on the Suicide Prevention, Intervention & Postvention Initiative of BC*.  
<http://suicidepipinitiative.files.wordpress.com/2009/05/suicide-pip-initiative-full-report.pdf>
- Loder, J., L. Bunt and J. Wyatt. (2013). *Dr. Know: A Knowledge Commons in Health*. London: The Young Foundation, March.
- Manitoba. (2011). *Rising to the Challenge: A strategic plan for the mental health and well-being of Manitobans*. <http://www.gov.mb.ca/healthyliving/mh/docs/challenge.pdf>
- Mental Health Commission of Canada (MHCC). (2013). *Making the Case for Investing in Mental Health in Canada*. Ottawa.  
[http://www.mentalhealthcommission.ca/SiteCollectionDocuments/January\\_2013/Case\\_for\\_Investment/Investing\\_in\\_Mental\\_Health\\_FINAL\\_ENG.pdf](http://www.mentalhealthcommission.ca/SiteCollectionDocuments/January_2013/Case_for_Investment/Investing_in_Mental_Health_FINAL_ENG.pdf)
- Mental Health Commission of Canada (MHCC). (2012). *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. Ottawa.  
<http://strategy.mentalhealthcommission.ca/pdf/strategy-images-en.pdf>
- Newfoundland and Labrador. (2005). *Working Together for Mental Health: A Provincial Policy Framework for Mental Health & Addictions Services in Newfoundland and Labrador*.  
[http://www.health.gov.nl.ca/health/publications/working\\_together\\_for\\_mental\\_health.pdf](http://www.health.gov.nl.ca/health/publications/working_together_for_mental_health.pdf)
- Nova Scotia. (2012). *Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians*.  
[http://www.gov.ns.ca/health/mhs/reports/together\\_we\\_can.pdf](http://www.gov.ns.ca/health/mhs/reports/together_we_can.pdf)
- Rush, B., K. Urbanoski, D. Bassani, S. Castel, T. Wild, C. Strike, D. Kimberley and J. Somers. (2008). "Prevalence of Co-occurring Substance Use and Other Mental Disorders in the Canadian Population." *Canadian Journal of Psychiatry*, 53(12): 800-809.
- Smetanin, P., D. Stiff, C. Briante, C. Adair, S. Ahmad and M. Khan. (2011). *The Life and Economic Impact of Major Mental Illness in Canada: 2011 to 2041*. Toronto: RiskAnalytica, December.
- Statistics Canada. (2003). *Canadian Community Health Survey: Mental Health and Well-being*. Ottawa.

**Appendix A**  
**Provincial/Territorial Mental Health Strategies**

**Up-to-date strategies**

**British Columbia** – November 2010

*Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Abuse in British Columbia.*

[http://www.health.gov.bc.ca/library/publications/year/2010/healthy\\_minds\\_healthy\\_people.pdf](http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf)

**Alberta** – September 2011

*Creating Connections: Alberta's Addiction and Mental Health Strategy.*

<http://www.health.alberta.ca/documents/Creating-Connections-2011-Strategy.pdf>

This strategy is enabled by *Creating Connections: Alberta's Addiction and Mental Health Action Plan 2011-2016.*

**Manitoba** – July 2011

*Rising to the Challenge: A strategic plan for the mental health and well-being of Manitobans, a five-year strategy.*

<http://www.gov.mb.ca/healthyliving/mh/docs/challenge.pdf>

September 2012: *Spiritual Health Care Strategic Plan, Health and the Human Spirit: Shaping the Direction of Spiritual Health Care in Manitoba*, a four-year plan.

<http://www.gov.mb.ca/healthyliving/mh/hhs.html>

**Ontario** – June 2011

*Open Minds, Healthy Minds*, a 10-year strategy.

[http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental\\_health2011/mentalhealth\\_rep2011.pdf](http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf)

**New Brunswick** – May 2011

*The Action Plan for Mental Health in New Brunswick, 2011-18.*

<http://www.gnb.ca/0055/pdf/2011/7379%20english.pdf>

**Nova Scotia** – May 2012

*Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians*, a five-year plan.

[http://www.gov.ns.ca/health/mhs/reports/together\\_we\\_can.pdf](http://www.gov.ns.ca/health/mhs/reports/together_we_can.pdf)

**National** – June 2012

Mental Health Commission of Canada: The release of *Changing Directions, Changing Lives: The Mental Health Strategy for Canada.*

<http://strategy.mentalhealthcommission.ca/pdf/strategy-images-en.pdf>

## **Early strategies**

**Quebec** – Quebec’s Mental Health Action Plan 2005-2010.

<http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2005/05-914-01.pdf>

During Mental Health Week 2011, the Quebec government announced that mental health is among its priorities and committed to developing a plan of action for 2012 to 2017. This plan will continue the work set out in the 2005-2010 action plan, which saw an \$80 million investment for mental health.

<http://communiqués.gouv.qc.ca/gouvqc/communiqués/GPQF/Mai2011/09/c2395.html>

**Newfoundland and Labrador** – in process/out of date – October 2005: *Working Together for Mental Health: A Provincial Policy Framework for Mental Health & Addictions Services in Newfoundland and Labrador.*

[http://www.health.gov.nl.ca/health/publications/working\\_together\\_for\\_mental\\_health.pdf](http://www.health.gov.nl.ca/health/publications/working_together_for_mental_health.pdf)

The 2011 Budget committed \$8.7 million to mental health initiatives, including an awareness campaign to fight stigma, an e-mental health program and peer support.

<http://www.budget.gov.nl.ca/budget2011/default.htm>

## **Alternate strategies**

**Northwest Territories** – June 2012

*A Shared Path Towards Wellness, 2012-15.*

[http://www.hss.gov.nt.ca/sites/default/files/a\\_shared\\_path\\_towards\\_wellness.pdf](http://www.hss.gov.nt.ca/sites/default/files/a_shared_path_towards_wellness.pdf)

**Nunavut** – a suicide prevention strategy and public health strategy (includes mental health), September 2011

*Nunavut Suicide Prevention Strategy Action Plan: September 1, 2011 – March 31, 2014.*

<http://www.tunnigavik.com/files/2011/09/nsps-action-plan-eng4.pdf>

## **No strategies**

**SK** – no strategy currently; May 2013 announcement that one is in development. June 2013 announcement that a commissioner has been appointed to lead the initiative.

<http://www.health.gov.sk.ca/Default.aspx?DN=73a49420-f5cb-474d-bd04-751d308528d>

**PEI** – in process

Website: “The Mental Health Services Strategy has several projects in various stages of completion. They include System Accountability, Service Coordination; Strategies for Children and Youth, Seniors and Concurrent Disorders; and a Human Resource Plan.”

<http://www.gov.pe.ca/peihealthsystems/index.php3?number=1038961&lang=E>

**YK** – nothing currently

[http://www.hss.gov.yk.ca/mental\\_health.php](http://www.hss.gov.yk.ca/mental_health.php)

## *Appendix B*

### *Highlights of Related Initiatives*

#### *Anti-bullying*

For children and youth, provincial/territorial anti-bullying strategies mainly take the form of awareness campaigns, particularly in relation to cyberbullying. Parents, teachers and children and youth are encouraged to get involved in learning more about the issue and reporting its occurrence.

Rather than focusing on bullying, the changes made to the *Alberta Education Act*, for example, are intentionally broad. According to one administrator: “Alberta is trying to move away from a zero tolerance/punishment paradigm and into one in which educators create welcoming, caring, respectful learning environments where bullying will not occur.”

The approach is also reflected in Nunavut’s 2008 *Developing Healthy Communities: A Public Health Strategy for Nunavut*. This wide-ranging document includes mental health considerations as one of its components. Its first priority – healthy children and families – states in its fourth goal that it seeks to “decrease the number of people experiencing mental, physical, emotional or sexual abuse, particularly children. Children require a safe nurturing environment for optimal physical, emotional and social development. Children who have been victims of maltreatment are at increased risk for violent behaviour, substance abuse, accidental injury, teenage pregnancy and becoming perpetrators of abuse. Programs which support parenting, education and mentoring help modify these factors” [Government of Nunavut 2008].

Workplace anti-bullying measures have been introduced in BC, Saskatchewan, Manitoba, Ontario and Quebec, signalling an increased awareness and profile of the power imbalances that underlie bullying. The recognition that bullying can occur in any environment and affect people of all ages is an important step in figuring out a meaningful approach to the problem.

#### *Provincial/territorial highlights*

##### *BC*

Action against workplace bullying: Amendments to the province’s *Workers Compensation Act* came into effect on July 1, 2012.

In June 2012, the *Expect Respect and a Safe Education* (ERASE) plan was introduced. This \$2-million, 10-point strategy to combat bullying is aimed to ensure that every child feels safe, accepted and respected.

<http://www.newsroom.gov.bc.ca/2012/06/premier-announces-erase-bullying-strategy.html>

January 22, 2013: The Provincial Office of Domestic Violence is requesting public feedback to help advance the development of a three-year provincial plan to address domestic violence.

<http://www.newsroom.gov.bc.ca/2013/01/bc-opens-public-domestic-violence-consultations.html>

## **AB**

Legislation to deal with bullying came in through amendments to Bill 3, the *Education Act*. The amendments were passed in fall 2012 but will not be enacted until 2015 in order to allow the time necessary to undertake regulation reviews. In the meantime, school boards are getting up-to-speed and making the policy changes they require to be in line with the updated legislation.

The province will not produce an anti-bullying strategy *per se*. In 2005, a draft strategy was put in place, but has since undergone substantial revision in order to reflect the direction of the Act. The new strategy, scheduled for release in Fall 2013, will be called the *Alberta Strategy for Promoting Healthy Relationships and Preventing Bullying*.

## **SK**

2013: In June 2013, residents were given the opportunity to discuss anti-bullying strategies and initiatives with Legislative Secretary to the Minister of Education (Anti-Bullying Initiative) through in-person and online consultations. The ideas and experiences shared during the consultations will help inform the development of an anti-bullying strategy for the province.

<http://gov.sk.ca/news?newsId=5331a8f9-15ba-4151-b34c-532c3cde7318>

2007: To address workplace bullying, the province expanded the definition of harassment under its *Occupational Health and Safety Act*.

## **MB**

2004: the Manitoba government made it law that schools must ensure safe and caring environments for all students.

2008: amendments were made to the *Public Schools Act* to expand the definition of bullying to include cyberbullying and require school boards to establish a policy regarding the appropriate use of the Internet and electronic mail, and digital and electronic devices.

2011: legislation established a province-wide approach to reporting serious student misconduct.

2011: to include protection from workplace bullying, the province made changes to its *Occupational Health and Safety Act*.

January 22, 2012: The province announces support for a two-year bullying awareness program that will help Brandon schools and communities learn how to address and prevent bullying, harassment and violent behaviour. *Beyond the Hurt* targets students in Grade 6 and up, to address why bullying and peer harassment happens and how to make it stop. Run by the Canadian Red Cross, the program uses a public health approach with an emphasis on building skills with students, teachers, parents and others to reduce and prevent incidents of bullying. (Provincial funding contribution: \$18,121)

December 2012: The province introduced an anti-bullying strategy, the *Safe and Caring School Anti-Bullying Action Plan*. It includes expanded training for teachers and ongoing support for a

Respect in School initiative, online information for parents and help for students (2011 strengthened anti-bullying legislation and an in-school survey to help students describe/talk about the issue).

### **ON**

2009: Ontario expands its definition of workplace harassment under the *Occupational Health and Safety Act* in order to address workplace bullying.

2009: *Ontario's Equity and Inclusive Education Strategy*  
<http://www.edu.gov.on.ca/eng/policyfunding/equity.pdf>

2011: Passage of Bill 14, an Act to designate Bullying Awareness and Prevention Week in Schools and to develop bullying prevention curricula, policies and administrative accountability in schools.  
[http://www.ontla.on.ca/web/bills/bills\\_detail.do?locale=en&Intranet=&BillID=2550](http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&Intranet=&BillID=2550)

2012: Passage of Bill 13, the *Accepting Schools Act*. The legislation will require all school boards to take preventative measures against bullying and support students who want to promote understanding and respect. An Accepting Schools Expert Panel was established to provide advice on evidence-informed resources and practices that focus on a whole school approach, including bullying prevention and intervention.  
<http://www.edu.gov.on.ca/eng/policyfunding/memos/june2012/Bill13eng.pdf>

### **QC**

2004: Quebec was the first province to pass legislation addressing workplace bullying, with its *Act Respecting Labour Standards*.

### **NB**

2012: As part of the three-year \$62-million *Strengthening Inclusion, Strengthening Schools*, the inclusion action plan to ensure healthy, safe and inclusive learning environments, the province has introduced initiatives to address bullying in schools, including:

- creating a provincial Anti-bullying Awareness Week to give students, school staff and parents the opportunity to openly discuss bullying and ways to prevent and reduce it
- implementing anti-bullying legislation which places greater emphasis on prevention, reporting, investigating and taking action when bullying occurs in schools
- hiring two bullying awareness and prevention coordinators to oversee and prevention and awareness across schools and districts.

<http://www.gnb.ca/0000/publications/comm/InclusionActionPlanReport.pdf>  
[http://www2.gnb.ca/content/gnb/en/news/news\\_release.2012.06.0494.html](http://www2.gnb.ca/content/gnb/en/news/news_release.2012.06.0494.html)

### **NS**

February 2012: *Report of the Nova Scotia Task Force on Bullying and Cyberbullying – Respectful and Responsible Relationships: There is No App for That* <http://www.unlikecyberbullying.ca/sites/default/files/downloads/cyberbullyingtaskforcereportmarch22.pdf>

February 9, 2013: The province has put new regulations into effect to adopt the common definitions for bullying and cyberbullying proposed by the Nova Scotia Task Force. These new regulations support the province's commitment to address the issue of bullying and cyberbullying with students, families, schools and communities as part of *Kids and Learning First*, the province's plan to help every child succeed.

<http://novascotia.ca/news/release/?id=20130208006>

#### **NL**

October 2012: Province-wide consultations were held on bullying and harassment for School District personnel, principals, teachers, school council chairs and parent representatives as well as intermediate and high school students. The consultations focused on finalizing a definition of bullying as it pertains to the education system; a Bullying Prevention and Intervention Protocol; and a consistent Code of Conduct to be used in all schools. Opportunities were also provided to suggest ways to address cyberbullying including the role of students, schools, parents and the larger community in preventing and responding to bullying behaviours.

February 2013: \$75,000 to help expand Roots of Empathy programming into more schools. By engaging children in positive social behaviours like sharing, taking turns and respecting others, the program has been shown to reduce the incidence of bullying and aggression when introduced at an early age. In addition to school-based efforts, Roots of Empathy resources are also being placed in parent resource kits, which will be delivered to new parents as part of the province's early childhood learning strategy, *Learning from the Start*.

<http://www.releases.gov.nl.ca/releases/2013/edu/0218n04.htm>

#### **YK**

2008: Implemented a Safe and Caring Schools policy

2012: Implemented a Sexual Orientation and Gender Identity policy

2013: A digital literacy working group is currently researching a policy on cyberbullying.

Staff and students in all schools are taught self-regulation skills. In addition:

- the "Mind-up" program teaches students to be aware of their responses to situations
- Social Responsibility Performance standards are taught to all students.

#### **NT**

June 2012: A new motion designed to introduce anti-bullying measures. If passed, it would call for amendments to the *Education Act* to include anti-bullying measures within 18 months.

## ***Autism***

Canadian estimates suggest one person in 94 has some form of autism; 4,900 Canadian teenagers with autism come of age each year [Ottawa Citizen 2013].

With the exception of Yukon and Nunavut, all jurisdictions offer some level of program support (mainly Intensive Behavioural Intervention) to parents of children ages 2 to 5. In all parts of the country, demand for service is outstripping supply, as awareness of Autism Spectrum Disorder (ASD) becomes more widespread and researchers continue to uncover new causes and propose new therapies – IBI is not a one-size-fits-all intervention. As children enter the education system, annual review procedures determine what level of support is appropriate. So long as children are under age 21 and/or continue in the education system, they are eligible for support.

### ***Provincial/territorial highlights***

#### ***BC***

2003: The BC Autism Assessment Network (BCAAN) is a program of the Provincial Health Services Authority. BCAAN is responsible for assessing and diagnosing children who may have autism. The goal of BCAAN is to provide timely assessment and diagnosis within reasonable distance of the child's home. BCAAN includes specialists and health care professionals throughout BC. Assessment services are provided by each of the five geographic health authorities. BCAAN ensures the standards and guidelines set by the Ministry of Health are met, and reports to the Ministry on behalf of its health authority partners.

The Ministry of Children and Family Development supports two Autism Funding Programs – Autism Funding: Under Age 6 and Autism Funding: Ages 6-18.

[http://www.mcf.gov.bc.ca/autism/funding\\_programs.htm](http://www.mcf.gov.bc.ca/autism/funding_programs.htm)

Dua, V. (2003). *Standards and Guidelines for the Assessment and Diagnosis of Young Children with Autism Spectrum Disorder in British Columbia: An Evidence-Based Report prepared for the British Columbia Ministry of Health Planning*. Vancouver: British Columbia's Children's Hospital.

#### ***AB***

Alberta Human Services' Family Support for Children with Disabilities includes a wide range of services and supports to children and families, such as autism therapy, respite service, child care and school support.

#### ***SK***

Beginning in 2009, funding to enhance autism services and supports has been provided through the Framework and Action Plan for Autism Spectrum Disorders Services in Saskatchewan, three-year Autism Spectrum Disorders Pilot Project Funding and enhancement initiatives in 2011-12 and 2012-13.

A Provincial Autism Advisory Committee (PAAC) was formed in May 2008 for the purpose of providing the Ministry of Health with information about current ASD services and supports, identifying

gaps in service delivery, and informing the development of a plan for accessible and equitable services and supports provincially.

The *Framework and Action Plan* was informed by the PAAC and community stakeholders. It is designed to support individuals affected by Autism Spectrum Disorder (ASD) by enhancing access to effective and efficient services and supports. It defines a vision, set of guiding principles and strategic directions for ASD services and supports throughout the province.

There are four key components to the Framework and Action Plan:

- 15 ASD Consultants act as first points of contact for parents. They review and process referrals, screen for ASD, coordinate assessment, treatment and program development, guide intervention and monitor individualized intervention plans. They provide consultation and support to ASD individuals up to age 19 and provide clinical supervision to the ASD Support Workers.
- 18 ASD Support Workers work directly with ASD clients from age birth until successful transition to school. They set the goals of the individualized program plan under the direction of the ASD Consultant and help parents to integrate the program plan into their daily lives.
- Seasonal programming and respite funding is provided on an annual basis to assist individuals and families that require support during off school hours.
- Province-wide training opportunities are provided annually for parents, caregivers, professionals and paraprofessionals, to ensure that a pool of trained individuals who are qualified to deliver a variety of intervention strategies, exists.

<http://www.health.gov.sk.ca/autism-action-plan-2008>

### **MB**

2009: Within *Opening Doors*, the provincial disability discussion paper, there are considerations for children with autism.

[http://www.gov.mb.ca/dio/pdf/opening\\_doors.pdf](http://www.gov.mb.ca/dio/pdf/opening_doors.pdf)

“In 2009-10, Children’s Special Services receives an additional \$2.7 million to increase the availability of services to families. In particular, additional spaces in the Applied Behaviour Analysis (ABA) program for pre-school children with Autism Spectrum Disorder will be made available as well as additional therapy interventions, respite service and assistive technology devices.” [page 6]

[http://www.gov.mb.ca/dio/pdf/opening\\_doors.pdf](http://www.gov.mb.ca/dio/pdf/opening_doors.pdf)

June 2011: *Thrive!* is a five-year plan for helping Manitobans with autism spectrum disorders. In 2011-12, the province committed to investing \$32.4 million for services to children with autism and their families:

- \$3.0 million to support families of children with autism through the Children’s disABILITY Services program
- \$6.6 million to support the Pre-school and School-age Applied Behaviour Analysis programs

- \$22.8 million specifically for children with autism in schools.

[http://www.gov.mb.ca/fs/thrive/pubs/thrive\\_brochure.pdf](http://www.gov.mb.ca/fs/thrive/pubs/thrive_brochure.pdf)

### **ON**

Children and Youth Services administers and Autism Intervention Program with five components: autism therapy; support services to families, including training; transition services and supports; School Support Program (185 autism consultants provide autism therapy training); and other supports and services, including respite. Children are eligible for the program between ages 2 and 5, and the autistic disorder or condition must be towards the severe end of the autism spectrum disorder.

Ministry website contains resources for parents of autistic children at:

<http://www.children.gov.on.ca/htdocs/English/topics/specialneeds/autism/findhelp.aspx>

### **QC**

2005: Autism Action Plan (*Plan d'action en autisme*). This is a comprehensive program that includes autism therapy for children ages 2 to 5. It provides preschool children for autism therapy with a minimum of 20 hours per week. Other programs exist for school-aged children and adults.

<http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2002/02-820-01.pdf>

April 2013: \$10 million in funding to be distributed among various regions of the province to improve services for young adults aged 21 and over with a pervasive developmental disorder (PDD) such as autism, intellectual disability or a physical disability. The \$10 million is to be added to the existing \$35 million fund which is aimed at improving overall services. The government is also establishing a working group to further investigate socio-professional activities options for people 21 or older with PDD.

<http://communiqués.gouv.qc.ca/gouvqc/communiqués/GPQF/Avril2013/08/c3449.html>

### **NB**

No specific strategy exists, though *Strengthening Inclusion, Strengthening Schools* includes autism considerations:

Ensure that more teachers, educational assistants and behaviour interventionists have access to training in evidence-based interventions for autism.

- Education and Early Childhood Development (EECD) will implement an integrated approach to autism training that will build internal capacity and ensure more teachers, educational assistants and support staff have access to evidence-based interventions from certified, qualified clinical staff.
- EECD will create an external quality standards committee made of up renowned local and international experts to ensure the approach is current and meets proven international evidence-based standards.

<http://www.gnb.ca/0000/publications/comm/InclusionActionPlanReport.pdf>

## **NS**

2011: *Autism Spectrum Disorder Action Plan*

*Press release details, April 12, 2011:*

The plan represents \$5.5 million in new investments, including \$4 million over two years to fully fund the Early Intensive Behavioural Intervention (EIBI) program. [http://www.ednet.ns.ca/files/reports/autism\\_report\\_en.pdf](http://www.ednet.ns.ca/files/reports/autism_report_en.pdf)

## **PEI**

Strategies and interventions which are evidence-based and have demonstrated effectiveness for individuals with Autism Spectrum Disorder are recommended and supported. Many of these strategies are based on the science of Applied Behaviour Analysis. Active parent involvement and ongoing communication should be encouraged as this maximizes learning opportunities and generalization of skills.

<http://www.gov.pe.ca/eecd/autismservices>

<http://www.gov.pe.ca/autismservices/>

2013: Health PEI is currently working toward an optimized system of services for children with special needs and their families.

## **NL**

Budget 2011:

- \$2.2 million for the expansion of the Applied Behavior Analysis program to Grades 1 and 2 with an investment of \$2.9 million in the next year to expand to Grade 3
- \$297,000 to add seven positions to enhance the diagnosis of autism and reduce wait times for speech language and occupational therapy services for children with autism and other diagnoses
- \$255,000 for the development of a regional office of the Autism Society of Newfoundland and Labrador in Western Newfoundland and the expansion of two therapeutic programs.

<http://www.budget.gov.nl.ca/budget2011/highlights/default.htm#healthcare>

## **YK**

2006: Yukon provides assessments for young people up to age 19. Health and Social Services provides young people up to age 19 funding for therapeutic interventions, respite services, supported child care, medical travel and assessment.

## ***Children and Youth***

Several jurisdictions have introduced child- and youth-focused strategies across multiple departments – e.g., BC’s 2008 *Strong, Safe and Supported*; AB’s 2008 *Children’s Mental Health Plan for Alberta*; *Healthy Child Manitoba*; NB’s Youth Services Partnership.

### ***Provincial/territorial highlights***

#### ***BC***

2008: *Strong, Safe and Supported – A Commitment to BC’s Children and Youth*

[http://www.mcf.gov.bc.ca/about\\_us/pdf/Strong\\_Safe\\_Supported.pdf](http://www.mcf.gov.bc.ca/about_us/pdf/Strong_Safe_Supported.pdf)

This strategy pre-dated the *Integrated Framework for Children and Youth*.

2008: *Children and Youth with Special Needs: A Framework for Action – Making it Work!*

This framework includes values and strategies to guide collaborative work.

[http://www.mcf.gov.bc.ca/spec\\_needs/pdf/CYSN\\_FrameWorkForAction\\_Combo\\_LR.pdf](http://www.mcf.gov.bc.ca/spec_needs/pdf/CYSN_FrameWorkForAction_Combo_LR.pdf)

#### ***AB***

1998: *Alberta Children and Youth Initiative*

This initiative is a partnership of government ministries working together on issues affecting children and youth.

[http://justice.alberta.ca/programs\\_services/safe/](http://justice.alberta.ca/programs_services/safe/Initiatives%20Library%20%20Safe%20Communitites%20Secretariat/ACYI.aspx/DispForm.aspx?ID=4)

[Initiatives%20Library%20%20Safe%20Communitites%20Secretariat/ACYI.aspx/](http://justice.alberta.ca/programs_services/safe/Initiatives%20Library%20%20Safe%20Communitites%20Secretariat/ACYI.aspx/DispForm.aspx?ID=4)

[DispForm.aspx?ID=4](http://justice.alberta.ca/programs_services/safe/Initiatives%20Library%20%20Safe%20Communitites%20Secretariat/ACYI.aspx/DispForm.aspx?ID=4)

2006: *Positive Futures – Optimizing Mental Health for Alberta Children & Youth – A Framework for Action, 2006-2016*

<http://www.health.alberta.ca/documents/mental-health-framework-child-06.pdf>

2006: *Prevention of Aboriginal Youth Suicide: An Alberta Approach – Spirit of Hope Newsletter*.

The Aboriginal Youth Suicide Prevention Strategy is a cross-ministry initiative of the Alberta Children and Youth Initiative. This includes the Ministries of Children’s Services, Health and Wellness, Aboriginal Affairs and Northern Development, Seniors and Community Support, Solicitor General and Public Security, Alberta Alcohol and Drug Abuse Commission, Alberta Mental Health Board and Education.

2008: *FASD 10-Year Strategic Plan*

<http://www.fasd-cmc.alberta.ca/uploads/1004/fasd10yrplanfinal86321.pdf>

2008: *Children’s Mental Health Plan for Alberta, Three Year Action Plan, 2008-2011*.

The three-year action plan is aligned with many cross-sectoral initiatives such as the Mentoring Partnership Strategic Plan, Student Health, Bullying Prevention, Aboriginal Youth Suicide Prevention, and Children and Youth with Complex Needs.

<http://www.health.alberta.ca/documents/mental-health-plan-children-08.pdf>

2009: *Policy Framework for Services for Children and Youth with Special and Complex Needs and Their Families*

[http://www.education.alberta.ca/media/1106995/policy\\_framework\\_children\\_youth\\_special\\_complex\\_needs.pdf](http://www.education.alberta.ca/media/1106995/policy_framework_children_youth_special_complex_needs.pdf)

### **SK**

2006: *A Better Future for Youth: Saskatchewan's Plan for Child and Youth Mental Health Services*  
The province undertook extensive stakeholder consultation in 2004-05 to inform the development of the plan which was developed in 2005-06.

The plan's goal was to increase capacity of the publicly-funded community child and youth mental health system to improve access, quality and quantity of child and youth mental health services in Saskatchewan. This was done through the development or enhancement of several key components: outreach services; distance specialist consultation (psychiatry, psychology and social work) to rural and remote areas; ongoing provincial skills training in evidence-supported approaches for staff; funding for the extension of the treatment plan into the home, school and community; and a client and system outcomes measurement system.

Currently, the province is engaged in integrating mental health and addiction services. Staff have developed tools for standardized screening, primary assessment and transition to other services.

<http://www.health.gov.sk.ca/better-future-youth>

### **MB**

2000: The Premier of Manitoba established the Healthy Child Committee of Cabinet and the Healthy Child Manitoba (HCM) Strategy. Its four key goals are aimed at ensuring that all children are:

- physically and emotionally healthy
- safe and secure
- successful at learning
- socially engaged and responsible.

Website descriptor: To help all children and youth reach their potential, HCM works with families to support their children within strong communities. Responding to research indicating the first five years of life are critical to a child's future development, the provincial government implemented the HCM Strategy – a network of programs and supports for children, youth and families. This nationally recognized strategy was set in legislation under *The Healthy Child Manitoba Act* in 2007.

<http://www.gov.mb.ca/healthychild/about/index.html>

The Healthy Child Committee of Cabinet includes all ministers whose portfolios incorporate issues affecting children, youth and families. The work of the Province's Healthy Child Advisory Committee – with representatives from parent-child coalitions, communities and sectors across Manitoba – was also addressed under this legislation.

HCM supports several evidence-based programs and initiatives which are implemented across the province and dedicated towards improving healthy child and youth development, and the mental health of children, youth and families. Among them are:

- Roots of Empathy (ROE) and Seeds of Empathy (SOE). ROE is a bilingual, universal and classroom-based program that increases pro-social behaviour and reduces physical aggression and bullying by fostering children's empathy and emotional literacy. SOE is the early-years version of ROE, providing an adapted curriculum for pre-school aged children.
- PAX is an evidence-based approach delivered in the school environment that fosters children's social, emotional and self-regulatory skills. New long-term studies have shown that, after playing PAX in Grade 1 only, students go on to do better in and graduate from school, with fewer special education services needed; have better mental health (including less suicidal thoughts and attempts), fewer smoking, alcohol and drug addictions; and are less involved in crime in their later years.
- The Teen Talk Program offers a continuum of reproductive health, mental health, sexuality, substance use and anti-violence education to youth both in and out of school. The program operates from a harm reduction perspective and utilizes an abstinence plus model.
- Towards Flourishing: Improving Mental Health Among Families in the Manitoba Families First Home Visiting Program. Funded through the Public Health Agency of Canada's Innovation Strategy, this project provides multiple levels of support to families and public health staff including mental health education for new parents, training in mental health promotion for public health staff, screening, improved access to services for families and enhanced community capacity to meet the mental health needs of families.

2007: *Together we are stronger: Building Manitoba's FASD Strategy* [http://www.gov.mb.ca/healthychild/fasd/fasdstrategy\\_en.pdf](http://www.gov.mb.ca/healthychild/fasd/fasdstrategy_en.pdf)

May 2012: Announcement of province-wide expansion of Fetal Alcohol Spectrum Disorder services <http://www.gov.mb.ca/chc/press/top/2012/05/2012-05-11-125500-14113.html>

## **ON**

2007: *Early Learning for Every Child Today: A Framework for Ontario Early Childhood Settings* provides a guide for curriculum in Ontario's early childhood settings.

[http://www.children.gov.on.ca/htdocs/English/topics/earlychildhood/early\\_learning\\_for\\_every\\_child\\_today.aspx](http://www.children.gov.on.ca/htdocs/English/topics/earlychildhood/early_learning_for_every_child_today.aspx)

2012: *The Youth Action Plan* builds on existing investments through the *Youth Opportunities Strategy* to provide youth at-risk with access to additional experiences to improve their lives and help them contribute to their communities through outreach, job opportunities, mentorship and recreation. The

plan makes new investments in 20 initiatives, including a commitment to develop a long-term Ontario Youth Strategy.

<http://www.children.gov.on.ca/htdocs/English/documents/topics/youthandthelaw/youthactionplan/yap.pdf>

2008: Part of the province's Poverty Reduction Strategy, the *Youth Opportunities Strategy* provides youth ways to work constructively within their communities, gain confidence, learn new skills and work towards a valuable work reference.

Under the direction of the Ministry of Child and Youth Services, government representatives are working with community agencies and police to develop more services and programs for youth in under-serviced areas across the province. The strategy includes:

- Summer Jobs for Youth Program: Provides young people ages 15 to 18 with summer jobs so they can get real work experience. The program includes six weeks of employment and a week before to learn about resumés, interviews and other useful life skills. They also get a week of post-employment support.
- Youth in Policing Initiative: Provides opportunities for youth ages 15 to 18 to work with police departments to help develop skills that could lead to a career in policing.
- Youth Outreach Worker Program: Outreach workers meet youth in the places they hang out to make sure they know about the programs and services available to them. The workers also encourage young people to get involved in positive projects in their community.
- *YouthConnect.ca*: This is an Ontario government website aimed at young people looking for help. The youth-friendly site features links to questions about health, education, getting a job, getting involved in the community and other sources of help.

<http://www.children.gov.on.ca/htdocs/English/topics/youthopportunities/yos.aspx>

## QC

2009: Youth Action Strategy, 2009-12. It includes measures to encourage youth entrepreneurship, career/education planning, and engagement through youth forums, regional investment funds and recognition of citizenship participation.

[http://www.jeunes.gouv.qc.ca/documentation/publications/documents/strategie-action-jeunesse-2009-2014\\_en.pdf](http://www.jeunes.gouv.qc.ca/documentation/publications/documents/strategie-action-jeunesse-2009-2014_en.pdf)

Page 38: The section entitled "For Our Collective Well-Being" presents strategies for promoting healthy lifestyles (\$6.75 million between 2006-12), and preventing and responding to risky behaviour (\$23 million) including addictions. On page 43: "The government has implemented various action plans to combat addiction, such as the 2006-11 *Plan d'action interministériel en toxicomanie* and the 2007-12 *Offre de service* for the *Services-dépendances* program." The strategy includes further actions to help vulnerable client groups, such as young children who are exposed to a parent's struggle with addiction and adolescents who are seen in youth centres for alcohol or drug problems.

2006-12: Action Plan on healthy eating and the prevention of eating disorders (*Investir pour l'avenir: Plan d'action gouvernemental de promotion des saines habitudes de vie et de prévention des problèmes reliés au poids*).

## **NB**

*Youth Services Partnership – website introduction:*

Youth Services Partnership (YSP) is a collaborative network that facilitates delivery of programs and services for youth at the local and provincial level. There are 10 YSP committees provincially. The partnership seeks to identify needs, available resources and innovative approaches to meeting the gaps in service delivery.

[http://www2.gnb.ca/content/gnb/en/services/services\\_renderer.10435.html](http://www2.gnb.ca/content/gnb/en/services/services_renderer.10435.html)

News release, June 2010: *Integrated service delivery demonstration sites underway*

“The provincial government has selected two demonstration sites – one on the Acadian Peninsula, the other in Charlotte County – as it moves forward with its plan to improve services for children- and youth-at-risk; children and youth with complex needs; and youth involved in the criminal justice system.

The sites will be established in the spring of 2011 in school districts 9 and 10. They represent the latest step in the implementation of sweeping reforms to services and programs for vulnerable children and youth. This child- and youth-centred approach, known as the Integrated Service Delivery framework, is intended to provide a range of services involving several departments concerned with children and youth, including Social Development, Education, Public Safety, Health, and Justice and Consumer Affairs.”

[http://www2.gnb.ca/content/gnb/en/news/news\\_release.2010.06.0990.html](http://www2.gnb.ca/content/gnb/en/news/news_release.2010.06.0990.html)

## **NS**

2007: *Our Kids Are Worth It: Strategy for Children and Youth*

[http://www.gov.ns.ca/coms/departement/documents/Our\\_Kids\\_Are\\_Worth\\_It.pdf](http://www.gov.ns.ca/coms/departement/documents/Our_Kids_Are_Worth_It.pdf)

Like the province’s mental health strategy, this document presents vision statements, a review of promising practices and general success outcome statements. Annual progress reports are posted at

<http://novascotia.ca/coms/families/ChildandYouthStrategy.html>

## **PEI**

2008: PEI Youth Substance Use and Addiction Strategy

November 2012: Child and Youth Services in Prince Edward Island

[http://www.gov.pe.ca/photos/original/fema\\_cayreport.pdf](http://www.gov.pe.ca/photos/original/fema_cayreport.pdf)

Spring 2013: Completion of a Mental Health and Addiction Services and Supports Review. Reviewers recommended a focus on child and youth services.

## **NL**

2008: *Poverty Reduction Strategy* includes initiatives which support youth at risk including:

- Youth Addiction Prevention and Early Intervention Program
- increased support for residential and transition services for youth through a supportive board and lodgings model
- expansion of the Community Youth Network to four additional sites

- pilot program to help disengaged youth reconnect to learning and return to school
- increased high school incentive allowance for families in receipt of income support whose children turn 18 while attending high school.

## **YK**

Yukon is developing a framework for The Early Years.

In 2009, the Mental Health Commission of Canada proposed the establishment of “Evergreen,” a mental health framework specific to children and youth. Yukon is working with McMaster University on a research project that tests the ability to implement the Evergreen framework in a small jurisdiction. This project will also inform the re-development of mental health services for children and youth.

## **NT**

2009: The Department of Municipal and Community Affairs announced a Youth Leadership Plan to improve the reach of its programs and services, and to develop longer-term, evidence-based strategies to guide future investments in youth. A consultation involving more than 500 youth and 128 youth-serving organizations was initiated in 2010 to inform the plan. The results of the 2011 “Forging the Future – Potential Leaders Conference” were also used to develop the plan.

<http://www.maca.gov.nt.ca/resources/maca-ylp-web.pdf>

2010: Launch of *Proud2bNWT*, a health and social promotion website for youth in the NWT.

[http://www.exec.gov.nt.ca/currentnews/prDetails.asp?varPR\\_ID=1470](http://www.exec.gov.nt.ca/currentnews/prDetails.asp?varPR_ID=1470)

2010: 18 projects are a part of the new *Active After School* Program. The projects are aimed at getting NWT youth more physically active.

[http://www.exec.gov.nt.ca/currentnews/prDetails.asp?varPR\\_ID=1496](http://www.exec.gov.nt.ca/currentnews/prDetails.asp?varPR_ID=1496)

2011: Creation of the Office of the Children’s Lawyer. Under the *UN Convention on the Rights of the Child* ratified by Canada in 1991, children have a right to be heard in proceedings affecting them.

<http://news.exec.gov.nt.ca/>

## **NU**

The Territory’s public health strategy covers many of issues relating to children and youth.

*Developing Healthy Communities: A Public Health Strategy for Nunavut* <http://www.hss.gov.nu.ca/PDF/Public%20Health%20Strategy%20-%20English%20final.pdf>

## **Health Promotion**

### **Provincial/territorial highlights**

#### **BC**

2011: The province launched *Healthy Families BC*, a \$68.7 million comprehensive health promotion program. <http://www.healthyfamiliesbc.ca/> The initiative builds on *ActNow BC*, a cross-government, multisectoral initiative launched in 2005 to make BC the healthiest jurisdiction to host the Olympic and Paralympic Games. Both programs use a whole system approach that supports multi-partner, multi-component health promotion strategies to prevent chronic disease.

2008: The Ministry of Healthy Living and Sport launched *Seniors in British Columbia: A Healthy Living Framework*, an action plan to support BC seniors in living healthy, active, independent lives.

#### **AB**

2002: *Healthy U* was developed as a public information and education campaign in 2002 to support and encourage Albertans to lead healthier lifestyles by providing them with access to information on healthy eating and active living. The 2012-2014 campaign supports parents and their children up to age 12 to develop healthy habits that will last a lifetime.

July 2008: *Alberta Alcohol Strategy*  
[http://aglc.ca/pdf/social\\_responsibility/AAS\\_Full.pdf](http://aglc.ca/pdf/social_responsibility/AAS_Full.pdf)

June 2008: *Alberta Tobacco Reduction Strategy: Sustaining the Moment*  
<http://www.albertahealthservices.ca/AddictionsSubstanceAbuse/if-res-atrs-report-2008.pdf>

#### **SK**

2003: *Healthier Places to Live, Work and Play: A Population Health Promotion Strategy for Saskatchewan*  
<http://www.health.gov.sk.ca/population-health-strategy>  
*This strategy contains considerations of mental health and outlines goals and strategies by which to address the issue.*

Its goal is to improve the conditions that support positive mental well-being by promoting resilience, connectedness and citizenship. It describes examples of successful population health approaches already under way in the province, Canada and internationally. The document does not list action plans or details of future efforts in the area of mental health.

#### **MB**

2012: *Health and the Human Spirit: Shaping the Direction of Spiritual Health Care in Manitoba*.  
[http://www.gov.mb.ca/healthyliving/mh/docs/health\\_human\\_spirit.pdf](http://www.gov.mb.ca/healthyliving/mh/docs/health_human_spirit.pdf)

*Healthy living strategy – Manitoba in Motion*  
<http://www.gov.mb.ca/healthyliving/hlp/activity.html>

### *Healthy Schools*

Healthy Schools is designed to promote the physical, emotional and social health of school communities. It is based on the assumption that good health is vital for learning and that schools are in a unique position to have a positive influence on the health of children, youth and their families.

<http://www.gov.mb.ca/healthyschools/#.UWhiFLXvv0w>

### *Back off Tobacco – Tobacco Education for Manitoba Students*

The site offers a resource package for teachers.

<http://www.gov.mb.ca/healthyliving/bot/>

### **QC**

2003: *Programme Nationale de Santé Publique, 2003-12.*

This document includes promotion and prevention measures aimed at mental health, youth and addictions.

<http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2008/08-216-01.pdf>

### **ON**

In 2013, Ontario's public health sector – organizations responsible for protecting and promoting residents' health – released *Make No Little Plans*, a joint plan that lays out a 15-20 year vision, mission, values and strategic goals for the public health sector. The product of consultations with the public health sector and many others in the health and non-health sectors, it outlines the sector's five shared strategic goals and eight collective areas of focus for the next three to five years. Healthy Ontario website includes information on diet, exercise, injury avoidance and smoking cessation.

<http://www.mhp.gov.on.ca/en/default.asp>

### **NB**

Increase mental fitness in the population by implementing elements of New Brunswick's Wellness Strategy in partnership with the lead Department of Wellness, Culture and Sport, and government and nongovernment partners.

2009: *Live Well, Be Well: New Brunswick's Wellness Strategy – 2009-13.*

<http://www2.gnb.ca/content/dam/gnb/Departments/hic-csi/pdf/Wellness-MieuxEtre/NewBrunswickWellnessStrategy2009-2013.pdf>

### **NS**

2007: Alcohol Strategy – Changing the Culture of Alcohol Use in Nova Scotia

[http://www.gov.ns.ca/ohp/publications/alcohol\\_strategy.pdf](http://www.gov.ns.ca/ohp/publications/alcohol_strategy.pdf)

2011: Nova Scotia Responsible Gaming Strategy 2011

<http://www.gov.ns.ca/gamingstrategy/ResponsibleGamingStrategy2011.pdf>

June 2012: *Thrive: A plan for a healthier Nova Scotia*. The government-wide effort has 34 recommendations and \$2.05 million in new funding for 2012-13. The plan focuses on physical activity and healthy eating.

<http://www.gov.ns.ca/news/details.asp?id=20120607002>

Addictions, Youth: “*SchoolsPlus*, part of Nova Scotia’s Child and Youth Strategy, is available in all school boards in the province. This program sees professionals and programs provide social work, health, justice, and addictions services for students and families in a convenient, familiar setting – a school in their community” [page 8].

Work to prevent suicide includes:

- providing funding to the Canadian Mental Health Association for the Communities Addressing Suicide Together initiative, which supports suicide-prevention community coalitions
- allocating funding for the Youth Project, which enables them to provide supports to lesbian, gay, bi-sexual, transgendered and intersex youth – a population at significant risk of suicide
- working with the Chief Medical Examiner to improve data collection for suicide deaths to better inform future policy and interventions
- directing funding toward the Sun Life Financial Chair in Adolescent Mental Health to develop an evidence-based guide to addressing suicide for clinicians, institutions and community-based organizations.

### **PEI**

PEI Strategy for Healthy Living – designed to address issues of smoking, obesity, activity, school completion and healthy eating.

[http://www.gov.pe.ca/photos/original/hss\\_hl\\_strategy.pdf](http://www.gov.pe.ca/photos/original/hss_hl_strategy.pdf)

PEI is in the process of developing a Provincial Wellness Strategy that will be ready in Fall 2013.

### **NL**

2006: *Achieving Health and Wellness-Provincial Wellness Plan for Newfoundland and Labrador* has seven wellness priorities, including mental health promotion, healthy eating, physical activity, tobacco control, injury prevention, child and youth development, and environmental health.

2007: *Active, Healthy Newfoundland and Labrador* – more than \$70 million has been committed to recreational and sport infrastructure, programming and athlete development.

[http://www.tcr.gov.nl.ca/tcr/publications/2007/active\\_healthyNL.pdf](http://www.tcr.gov.nl.ca/tcr/publications/2007/active_healthyNL.pdf)

### **YK**

2013: Yukon will be introducing “Flourishing,” a mental wellness initiative, in late 2013. Based on Martin Seligman’s work, it will focus on Positive Emotions, Engagement, Relationships, Meaning and Achievement.

February 2013: A \$250,000 annual investment into active living programs to boost physical activity, combat rising rates of childhood obesity, promote active living and support a variety of programs for individuals, schools, and workplaces. *Renewed Yukon Active Living Strategy* is one of Yukon's healthy living initiatives. Along with the *Social Inclusion and Poverty Reduction Strategy* and the *Pathways to Wellness* initiative, these three programs share resources to increase access to sport and recreation, healthy living, healthy eating and a higher quality of life.

<http://www.gov.yk.ca/news/13-033.html>

Pathways to Wellness website, sponsored by Health and Social Services.

[www.YukonWellness.ca](http://www.YukonWellness.ca)

***NT***

2011: Launch of the *My Voice, My Choice* campaign empowers young people to talk about how addictions affect them and provides them with information about where to go for help.

<http://news.exec.gov.nt.ca/>

## ***Housing/Homelessness Federal and provincial/territorial highlights***

### ***Federal***

February 2008: The federal government allocated \$110 million to the Mental Health Commission of Canada to find ways to help the growing number of homeless people who live with a mental illness. The Commission developed the At Home/*Chez Soi* project launched in November 2009.

The research demonstration project was based on the Housing First approach, which provides people living with mental health problems with housing and support services tailored to their needs. Projects are under way in Moncton, Montreal, Toronto, Winnipeg and Vancouver.

<http://www.mentalhealthcommission.ca/English/Pages/homelessness.aspx>

### ***BC***

Under the *Provincial Homelessness Initiative*, BC works in partnership with communities, the federal government and nonprofit providers to develop new housing options with support services to help individuals who are homeless or at risk move beyond temporary shelter to more secure housing.

Through the 2006 provincial housing strategy, *Housing Matters BC*, the province has committed to developing more than 6,000 new and upgraded supportive housing units and shelter beds under the Provincial Homelessness Initiative. It is funded in part through the Canada-BC Affordable Housing Initiative.

[http://www.bchousing.org/resources/About%20BC%20Housing/Housing\\_Matters\\_BC/Housing\\_Matters\\_BC\\_FINAL.pdf](http://www.bchousing.org/resources/About%20BC%20Housing/Housing_Matters_BC/Housing_Matters_BC_FINAL.pdf)

Updates are available at <http://www.housingmattersbc.ca/>

Two primary policy changes and six strategies form the basis of *Housing Matters BC*. The two policy changes are:

- individuals or households with special housing needs will be given priority access to subsidized housing
- provincially owned subsidized housing will be renovated to better meet the needs of low-income households with special needs, such as seniors with enhanced accessibility requirements. Older, obsolete buildings on under-utilized land will be redeveloped to serve more households in need of housing assistance.

The six strategies are:

- the homeless have access to stable housing with integrated support services
- BC's most vulnerable citizens receive priority for assistance\*

\* Vulnerable citizens include women and children fleeing abuse, seniors, adults with development disabilities and young people ages 19 to 24.

- Aboriginal housing need is addressed
- low-income households have improved access to affordable rental housing
- homeownership is supported as an avenue to self-sufficiency
- BC's housing and building regulatory system is safe, stable and efficient.

*January 25, 2013:* Minister Responsible for Housing joined community partners and private donors in congratulating Streetohome Foundation for reaching its \$26.5-million fundraising goal to help end homelessness in Vancouver. Streetohome launched its fundraising campaign in May 2010 and committed to help build eight new supportive housing developments with the province and the city (Streetohome committed to raise \$20 million, the province invested \$200 million and the City of Vancouver contributed the land). The partners will create 950 supportive apartments, affordable homes with supports and services for those who are homeless or at risk of homelessness.

<http://www.newsroom.gov.bc.ca/2013/01/province-congratulates-streetohome-foundation.html>

### ***BC Housing considerations for youth in care or youth with other social/mental health needs***

The *Child, Family and Community Service Act* defines youth as over age 16 but under age 19.

A variety of services and supports are offered to vulnerable youth receiving care through the Ministry of Children and Family Development (MCFD) or a Delegated Aboriginal Agency to prepare them for every aspect of life in their transition into adulthood. These include:

#### *Youth in Care*

- plans of care include assessment of needs to support transitioning to independence and a plan to meet those needs
- supported independent living homes or transition homes (in-home supports – for example, for youth with mental health or substance use issues, or special needs)
- life skills coaching/courses (e.g., renting and tenancy, managing money, self care, finding employment, personal planning)
- supportive adults such as foster parents, mentoring landlords or one-on-one transition/support workers, which can also be offered to youth in a Youth Agreement (see below)
- start-up funds for living independently
- outreach workers and emergency shelters/safe houses can also support youth-in-care who may find themselves temporarily homeless if they absent themselves from foster or group home care.

#### *Youth who are not in care*

- services such as parent/teen mediation to support a youth residing with parents or to work on planning a return to family
- if a youth must reside away from family, placement with extended family is considered
- outreach workers and emergency shelters/safe houses support youth, exiting homelessness, street entrenchment and exploitation by helping them to return to family, enter into a longer-term service plan with the Ministry (i.e., a Youth Agreement) or connect with other available community services.

- Youth Agreements
  - o can provide homeless, high-risk youth with financial assistance through a Plan for Independence
  - o The plan may include finding a safe place to live, meeting basic living and health needs, reconnecting with school and/or family, and job readiness training. It may also include problematic substance use and mental health treatment.
  - o youth are not considered to be in-care as parents retain guardianship of these youth.

*Transition years programming*

- For youth with mental health issues who may need continued mental health services after turning 19, regional transition protocol agreements have been established between MCFD and Regional Health Authorities in many communities to guide transition planning. A review of these protocol agreements has recently been undertaken to improve transitions to adult services.
- Supported independent living homes or transition homes (provides in home supports – for example, for youth with mental health or substance misuse issues, special needs) are available in some communities in BC.
- To help youth with mental health issues transition to adult services, a supported-independent living program provides transitional housing for youth ages 18 to 22 in the Lower Mainland.
- A Cross-Ministry Transition Planning Protocol for Youth with Special Needs came into effect November 1, 2009. The Protocol is an agreement among nine government organizations on how they will work together to support the transition of youth with special needs to adulthood.

**AB**

2009: Adoption of *A Plan for Alberta: Ending Homelessness in 10 Years*, a 10-year plan to eliminate homelessness; \$3.2 billion spent in 2009-12 on capital investments and operating funding. It supports municipal plans to end homelessness. The plan adopts a ‘Housing First’ approach of providing immediate housing along with client-centred supports such as mental health services, addictions counselling and employment training.

<http://alberta.ca/albertacode/images/AlbertaPlantoEndHomelessness.pdf>

February 7, 2013: Release of the final progress report from the Alberta Secretariat for Action on Homelessness. Since 2009, more than 6,600 homeless people have been provided with housing and supports, and more than 1,600 people left Housing First Programs and are living independently.

It was also announced that the Alberta Interagency Council on Homelessness has been appointed. The community-focused partnership will help guide the next phase of *A Plan for Alberta: Ending Homelessness in 10 Years*. The focus is now shifting to making long-term changes that will prevent homelessness and strategies requiring coordinated action between government and local communities.

<http://alberta.ca/NewsFrame.cfm?ReleaseID=/acn/201302/33643B565CE62-DA05-98DE-3A898831D9F65D94.html>

## **SK**

2011: Release of *A Strong Foundation – The Housing Strategy for Saskatchewan 2011-19* and the *2011-12 Provincial Action Plan*, which outlines key activities for the first year of implementation.

<http://www.socialservices.gov.sk.ca/Housing-Strategy-2011-19.pdf>

In March and April 2011, the Saskatchewan Housing Corporation held strategy consultations with 350 housing stakeholders throughout the province to tackle these issues and set out tangible solutions. These discussions resulted in five broad strategic priorities:

- increase the housing supply
- improve housing affordability
- support individuals and families in greatest housing need
- enhance strategic planning for housing
- collaborate, communicate and educate.

*Update on The Housing Strategy For Saskatchewan – April 2012* tracks progress on the five priority areas.

<http://www.socialservices.gov.sk.ca/2012Update-HousingStrategy.pdf>

*The Housing Strategy for Saskatchewan Provincial Action Plan 2012-13*

The document lists 35 actions.

<http://www.socialservices.gov.sk.ca/Housing-Action-Plan-2012-13.pdf>

## **MB**

2011: Housing and Community Development developed *Strong Communities – An Action Plan* through multi-stakeholder consultations, which established six goals to guide department activities. The goals include: promote and support community development, build greater community capacity, sustain existing social and affordable housing stock, address affordability and increase supply of quality affordable housing, enhance client opportunities and services, and build capacity of Manitoba Housing and Community Development.

2013: Manitoba Housing developed a three-year *Housing Plan (2013-2016)*. The plan established five priority areas that support the goals set out in *Strong Communities*. Included in the plan is a priority entitled *Working with People*, which emphasizes a people-focused approach to social and affordable housing. The approach includes provision of a range of housing options and services to meet the housing needs of vulnerable populations, including those with mental health issues, to promote successful tenancies.

## **ON**

2010: *Building Foundations, Building Futures: Ontario's Long-Term Affordable Housing Strategy* and the *Housing Services Act, 2011* complete the devolution of social and affordable housing to Ontario's 47 municipal Service Managers.

<http://www.mah.gov.on.ca/AssetFactory.aspx?did=8590>

## **QC**

April 2009: *Plan québécois des infrastructures* [Quebec infrastructure plan] to improve social housing in the province. 72,000 *habitations à loyer modique* [low rent housing] valued at \$7.5 billion will be maintained and modernized.

October 2009: \$820 million over two years by federal and provincial governments to build and renovate affordable housing.

2009: Quebec launches a \$60.5 million, three-year plan to fight homelessness, including measures to improve mid- and long-term housing options for people on the street. As part of the plan, the *Société d'habitation du Québec* was to reserve 300 new units between 2010 and 2013 for homeless people moving off the street.

2013: Quebec is currently working on a homelessness policy. Now in the consultation phase, the final document is expected to be released in Fall 2013.

## **NB**

2010: Release of *Hope is a Home*, a five-year plan to reduce poverty by making housing more affordable. The strategy recognizes the need to build new units of affordable housing, create mixed-income neighbourhoods, revitalize old neighbourhoods, and repair and renovate older housing stock. *Hope is a Home* includes a homelessness framework, *A Home for Everyone*.

<http://www2.gnb.ca/content/dam/gnb/Departments/sd-ds/pdf/Housing/housingstrategy-e.pdf>

## **NS**

No strategy at this time.

*January 22, 2012 news release: Hundreds Help Shape Province's Housing Strategy* in response to the discussion paper, *A Housing Strategy for Nova Scotia*.

<http://novascotia.ca/news/release/?id=20130122005>

## **PEI**

No housing or homelessness strategy exists but a government contact states that much work has been undertaken in the creation of new affordable housing units across the province. Since 2007, 340 new units have been created through federal-provincial Affordable Housing Agreement.

*2011 PEI Report on Homelessness*

The report deals with both the homeless and the working poor on issues that affect both populations.

<http://homelesshub.ca/ResourceFiles/Report%20on%20Homelessness%202011%20Final.pdf>

## **NL**

2009: Release of *A Social Housing Plan for Newfoundland and Labrador – Secure Foundations*. \$23.6 million for housing investments for social housing renovations and energy retrofits, social housing units for low-income seniors and a Provincial Homelessness Fund to help nonprofit community groups provide wrap-around services for complex needs clients.

<http://www.nlhc.nl.ca/SocialHsingPlan/report.pdf>

October 2009: \$95,000 for NL Housing and Homelessness Network, a new homelessness initiative comprising representatives from nonprofit organizations, municipal, provincial and federal governments, the private sector and individuals who have experienced homelessness. Funds were made available through the Supportive Living Community Partnership Program, a \$1.2 million fund announced in Budget 2009.

<http://www.releases.gov.nl.ca/releases/2009/hrle/1005n01.htm>

2011: Additional \$2.4 million in funding for the Supportive Living Community Partnership Program, for a total of \$4.8 million, double the amount that was available in 2010-11. This program helps individuals with complex needs overcome homelessness.

2012: Newfoundland Housing Corporation's programming promotes housing stability for vulnerable people and is designed to help individuals stay in their homes or obtain affordable housing. Investments include:

- \$8 million to the Provincial Home Repair Program. This program provides approximately 2,500 low-income homeowners with home upgrades
- \$5.4 million investment in the Affordable Housing Initiative to enable approximately 245 additional affordable housing units to be constructed. The total three-year investment for this program is \$16.2 million.

## **YK**

2011: Not a government strategy, the Yukon Anti-Poverty Coalition released *A Home for Everyone: A Housing Action Plan for Whitehorse*. Developed through workshops, research and input from community members, the plan focuses on ideas to provide better housing options.

<http://www.yapc.ca/assets/files/a-home-for-everyone.pdf>

December 2012: Release of *A Better Yukon for All*, the government's Social Inclusion and Poverty Reduction Strategy. It includes initiatives to help improve the lives of vulnerable populations, including the expansion of the Dawson City women's shelter and the Downtown Outreach Clinic in Whitehorse, which provides home care services to homeless people. Its three goals are to improve access to services, reduce inequities and strengthen community vitality. The strategy is available online at

[www.hss.gov.yk.ca](http://www.hss.gov.yk.ca).

<http://www.gov.yk.ca/news/12-245.html>

## **NT**

*Small Community Homelessness Fund Criteria and Guidelines 2012-13* published by Northwest Territories Housing Corporation, September 2012.

[http://nwthc.gov.nt.ca/\\_live/documents/content/](http://nwthc.gov.nt.ca/_live/documents/content/)

[Small%20Community%20Homelessness%20Fund%20Criteria%202012.pdf](http://nwthc.gov.nt.ca/_live/documents/content/Small%20Community%20Homelessness%20Fund%20Criteria%202012.pdf)

## **Recreation**

### **Provincial/territorial highlights**

#### **BC**

*Neighbourhood Learning Centres* are building stronger families and have connected communities by co-locating schools, sports groups, nonprofit organizations and social activities.

<http://www.neighbourhoodlearningcentres.gov.bc.ca/welcome.php>

#### **AB**

2011: *Active Alberta Policy: 2011-2021*

<http://tpr.alberta.ca/activealberta/docs/ActiveAlbertaPolicy.pdf>

#### **SK**

*From the Saskatchewan Parks and Recreation website (accessed January 24, 2013):*

Over the past two years, Saskatchewan Parks and Recreation and the Ministry of Tourism Parks Culture and Sport have been discussing the development of a Provincial Recreation Strategy. An Environmental Scan has been completed and submitted to the Ministry.

<http://www.spra.sk.ca/resources-and-advocacy/advocacy/advocate-for-recreation/saskatchewan-recreation-strategy—environmental-s/>

#### **MB**

2008: *Reclaiming Hope: Manitoba's Youth Suicide Prevention Strategy*

A key component of Manitoba's youth suicide prevention strategy is the Winnipeg Aboriginal Sport Achievement Centre (WASAC) North. WASAC North aims to increase opportunities for Aboriginal children and youth to become more physically active and develop leadership abilities to promote continuing education, self-esteem, life skills and community development. The program is active in six Aboriginal communities and provides activities involving sport, recreation, leadership and culture with community youth, service providers, schools and leadership.

Getting “in Motion” is the provincial strategy to help all Manitobans make physical activity part of their daily lives for health and enjoyment. Tools and resources are available to help individuals, families, communities, workplaces and schools plan and implement ways to get “in motion.”

<http://www.gov.mb.ca/healthyliving/hlp/activity.html#inmotion>

#### **ON**

Active 2010: *Ontario's Sport and Physical Activity Strategy*

<http://www.mhp.gov.on.ca/en/active-living/about/active2010-strategy-e.pdf>

Youth-focused elements of the strategy – see pages 15 and 20.

#### **QC**

The purpose of *Québec en Forme* is to promote the adoption and maintenance of healthy eating habits and a physically active lifestyle for youth up to age 17.

**NS**

2007: *Active Kids, Healthy Kids*

<http://www.gov.ns.ca/hpp/publications/AKHK-Strategy.pdf>

**PEI**

2013: Launch of *Active Start*, a recreation program for children ages 3 to 6.

**NL**

2008: \$100,000 was invested in the community-based Canadian Tire *JumpStart* program which assists thousands of young people.

**NT**

2011: \$615,000 in government funding to support physical activity through the *Active After School Initiative*.

<http://news.exec.gov.nt.ca/>

2011: *Get Active NWT* grants have been awarded to 78 community groups to organize events that will help residents get active. Applications were received from groups in all 33 communities.

<http://news.exec.gov.nt.ca/78-get-active-nwt-grants-awarded/>