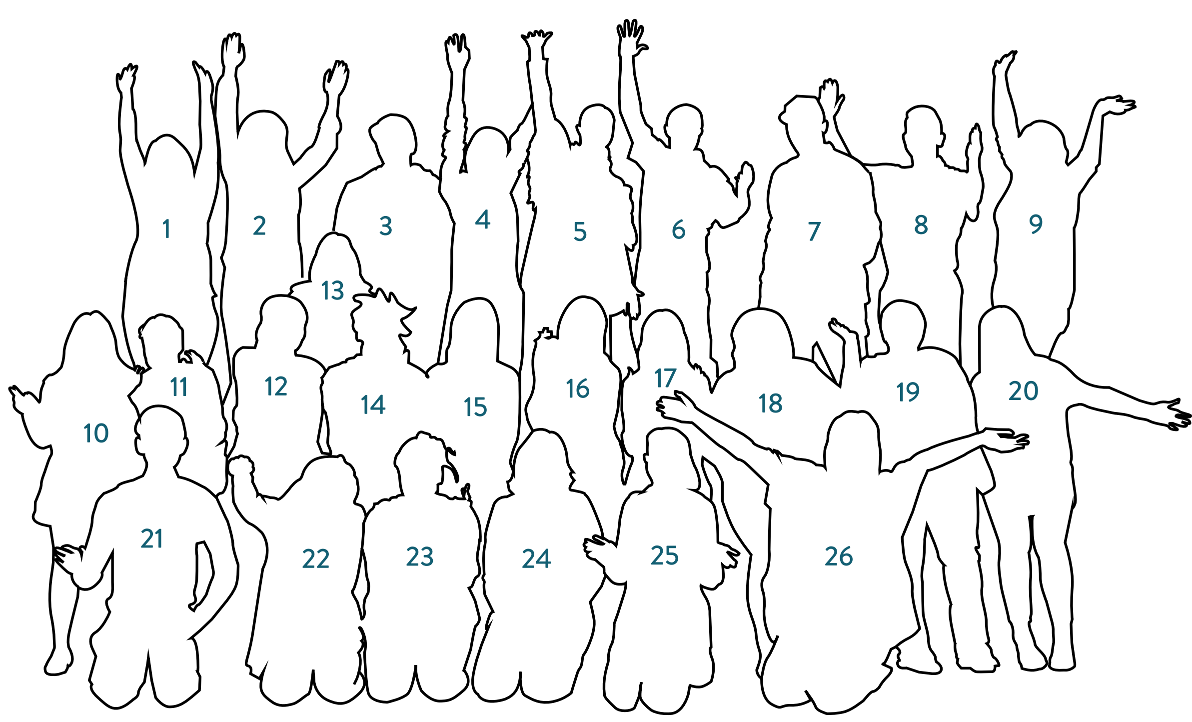
KNOWLEDGE IS POWER | ACTIONS FOR ACCESS | INSIGHT ON TRAUMA

LEGACY

PROGRESS OF THE CHILD AND YOUTH MENTAL HEALTH AND SUBSTANCE USE COLLABORATIVE

WHAT HAS THE COLLABORATIVE MEANT *to you?*

YOUTH OF THE COLLABORATIVE
& THEIR LOCAL ACTION TEAMS (LATs)



1 Jasmine Rakhra - Saanich Peninsula and Victoria LATs
2 Lindsey Byrnes - Abbotsford LAT
3 Jared French - Prince George LAT
4 Miranda Pattyn - North Shore LAT
5 Rylee McKinlay - South Okanagan Similkameen LAT
6 Corey Reid - Langley LAT
7 Tyler Exner - West Kootenay LAT
8 Myles Mattila - Prince George LAT
9 Denise Askin - Delta LAT
10 Christine Camaso - Sooke West Shore LAT
11 Markus Meyer - Sooke West Shore LAT
12 Destiny Davidson - Haida Gwaii North LAT
13 Megan Ives - Haida Gwaii South LAT
14 Jaden Reinhardt - Haida Gwaii North LAT
15 Meryssa Waite - Comox Valley LAT
16 Kirsten Funk - Ridge Meadows LAT
17 Ruby Kells - Quesnel LAT
18 Teesha Sharma - Ridge Meadows LAT
19 Christy Rose - Prince George LAT
20 Taylor Mahovlich - Sooke West Shore LAT
21 Bowen Haselhan - Cariboo LAT
22 Lajah Warren - Sooke West Shore LAT
23 Danica Miscisco - Ridge Meadows LAT
24 Joely Graham - Ridge Meadows LAT
25 Miranda Tymoschuk - Ridge Meadows LAT
26 Laurie Edmundson - Surrey/North Delta LAT

The Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative is funded in partnership by Doctors of BC and the BC government

LEGACY MARCH 2017

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On the cover: Youth delegates at Learning Session 8 in Vancouver, October 2016. Photo by Robert Leon.

CYMHSU COLLABORATIVE

FAST STATS

PEOPLE

2,650 PARTICIPANTS

255 PHYSICIANS

158 GPs

97 SPECIALISTS

295 YOUTH & PARENTS

422 HEALTH AUTHORITY STAFF

201 FIRST NATION AGENCIES

184 COMMUNITY SERVICE AGENCIES

205 MCFD STAFF

MINISTRY OF CHILDREN & FAMILY DEVELOPMENT

383 SCHOOL PERSONNEL

(TEACHERS, COUNSELLORS, PRINCIPALS)

110 RCMP

50 ELECTED OFFICIALS AND MUNICIPAL STAFF

ACTIVITIES

MARCH 2015-DECEMBER 2016

363 ACCESS INITIATIVES

268 MENTAL HEALTH LITERACY ACTIVITIES

142 SCHOOL-BASED INITIATIVES

30 SURVEYS

82 WEBSITES, DIRECTORIES, INVENTORIES, RESOURCE CARDS

16 FACEBOOK & INSTAGRAM ACCOUNTS

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FROM THE CO-CHAIRS

AN EXPERIMENT IN COLLABORATION CREATES NEW WAYS TO HELP BC FAMILIES

BY VALERIE TREGILLUS & MANJIT BAINS

AS CO-CHAIRS OF THE STEERING COMMITTEE for the Child and Youth Mental Health and Substance Use Collaborative, a partnership of Doctors of BC and the BC government, we are delighted to present *Legacy* magazine. These pages are filled with stories and inspiration about some of the many activities that participants in the CYMHSU Collaborative have undertaken since Spring 2013.

Looking back to when we were just eight Local Action Teams and about 250 people in the Interior, it is hard to believe how far we have come in four years.

We had joined together because we were worried about the uncoordinated system of mental health care for children, youth, and families in BC. As a first of its kind in Canada, the Collaborative decided to explore new ways of working together and to attempt tests of change to increase the number of children, youth, and families seeking and receiving timely access to integrated mental health and substance use services and supports.

Now we have grown ten-fold, numbering more than 2,650 people — youth and families, family doctors, pediatricians, psychiatrists, mental health clinicians, school counsellors, teachers and principals, First Nations, health authority reps, RCMP/police, community agencies, and more.

We have 64 Local Action Teams (LATs) across the province, some with more than 100 members. Each LAT has committed to specific community-based activities to help improve mental health and substance use literacy, access, service provision, and outcomes for children and youth with mental health and substance use concerns in their region.

Eleven system-level working groups have taken up issues and barriers that are too big or too complex for local teams to tackle on their own, such as an emergency room protocol or the recruitment and retention of child and adolescent psychiatrists in BC.

Our Steering Committee and two advisory clinical faculties — one on mental health concerns and the other on substance use issues — oversee all the work. In 2016 we added four youth with lived experience to our Steering Committee; their dedication and inspiring input has invigorated our activities.

As you'll learn in these pages, this approach has unleashed creative and inspiring actions around BC to help increase mental health literacy, improve access to and awareness of services, provide more coordinated and collaborative care, and help identify clearer pathways to wrap care around children, youth and families, and connect them, when needed, to timely complex care.

None of this would have been possible without the support of key individuals and agencies: Shared Care and the other Joint Collaborative Committees of Doctors of BC and the BC government; the Ministries of Health, Education, and Children and Family Development; and the five health authorities — Northern, Interior, Island, Fraser, and Vancouver Coastal — as well as the Provincial Health Services Authority and the First Nations Health Authority. Numerous other provincial agencies have played key roles: The Institute of Families/FORCE Society for Kids Mental Health, the Canadian Mental Health Association, the RCMP, BC Children's Hospital, the Superintendents of Schools, and all the BC school districts. Regional and community agencies are too numerous to mention, but we thank them all.

We have accomplished a lot and much is still left to do. We look forward in our final year to even more collaborative work to make sustainable, significant changes.

Valerie Tregillus is Project Director, CYMHSU Collaborative
Manjit Bains is Operational and Management Performance Director, Ministry of Children and Family Development

WHAT HAS THE COLLABORATIVE *meant to you?*

HOPE, OPPORTUNITY, HEALING, TRUST AND MUCH MORE

The Collaborative has close to 300 youth and families with lived experience on Local Action Teams and participating in the Learning Sessions. They are the beating heart of all the Collaborative's activities. Their experience, knowledge and energy are improving BC's child and youth mental health and substance use system not only for themselves but for all the youth and families who come after them. We asked some of the youth: "What has the Collaborative meant to you?" Here are their answers.

TEESHA SHARMA

Ridge Meadows LAT

It's been incredible — all these amazing people pulling together to make things better for other kids like me! It has given me opportunities to share my lived experience and my energy to make a difference. It is restoring my trust, my hope, and my optimism. It has been healing and empowering.

TYLER EXNER

West Kootenay LAT

It means a lot less stigma and a lot more awareness. It's definitely made me more open about my struggles and my story. And it's just been getting easier and easier for me to share it. And the system's just getting better. I can just see the improvement over the last couple of years.

BRENT SEAL

Learning Session MC

It means we have a voice, and an influence on the mental health system, we connect with other youth, parents and service providers, we share a lived experience perspective, we get the recognition from decision makers and others that our lived experience has value. All this has been amazing and has never happened to the same depth and scope prior to the Collaborative.

RYLEE MCKINLAY

South Okanagan Similkameen LAT

It's been a really integral part of my recovery. When we first started I was still fairly sick; I'd just gotten discharged from the hospital. It has helped me be accountable. I'm an advocate, not just another victim. I'm part of making the change.
It's opened up so many opportunities for me.

COREY REID

Langely LAT co-chair

It has given me a sense of belonging I've never had before. That I didn't go through everything I went through for nothing. It's given me a lot of hope in myself and for all the other young people that I come into contact with on a daily basis. It means empowerment, engagement.

MYLES MATTILA

Prince George LAT,
co-chair Youth Action Team

It means that instead of being out there all by myself talking about the importance of mental health, we are now a whole network, backing each other up, sharing ideas and inspiration, creating a community that is all pulling together.

LAURIE EDMUNDSON

Surrey/North Delta LAT
Project Lead

It means hope, empowerment, meaning. It means that our lived experience actually means something, like we went through all of that for a reason, which is huge — that it'll actually benefit other people. For me, it gives me so much opportunity to give back.

CHRISTINE CAMASO

Sooke/West Shore LAT

It means different people from different fields coming together for one cause that truly matters to them — us youth. It makes me feel safer and more secure knowing that I have all these people behind me, knowing they'll catch me, or my peers, if any one of us falls.

JASMINE RAKHRA

Saanich Peninsula, Victoria LATs

The Collaborative has given me a voice and an outlet to express myself —something I didn't have for 10 years growing up in a home where I was abused day after day. From my years of suffering, I want to share my gift of my presence and how we can collaboratively improve our broken system to create systematic and groundbreaking change.

GROWING ON *fertile* GROUND

HOW A COOPERATIVE CULTURE SEEDED THE CYMHSU COLLABORATIVE

A complex, province-wide initiative like the CYMHSU Collaborative, doesn't just materialize. In fact, a little known, pre-disposing factor occurred a decade ago that made the Collaborative possible, notes Valerie Tregillus, project director of the Collaborative. In 2003 BC doctors and the government decided to put aside years of strife and to focus on ways they could cooperate to improve health in BC.

As documented in an in-depth case study by the Collaborative evaluators, the dramatic shift occurred back then because of numerous factors, particularly a crisis in full-service family practice. The family doctor is the backbone of the Canadian health system, but GPs were feeling overwhelmed, overworked, and underappreciated. They were leaving or limiting their practices and not enough new doctors were choosing family medicine.

FROM ADVERSARIES TO ALLIES

Doctors of BC and the government knew they had to cooperate to find ways to support full service family doctors. Using earmarked funds from the Physician Master Agreement (PMA), which governs physician compensation, they created the **GP Services Committee** (GPSC), the first of its kind in Canada. The GPSC began funding new initiatives, including special incentive payments for more time-consuming, complex care; training programs to help with challenging clinical or administrative issues; and other projects to support, train, and value GPs' essential role in the BC health system.

By 2006, the GPSC's success spurred the creation of two more collaborative committees funded out of the PMA: the **Specialist Services Committee** (SSC), aimed at fostering collaboration in acute care settings with specialist physicians, and the **Shared Care Committee** (SCC), aimed at helping to integrate GPs, specialists and other allied health professionals to improve the patient's journey through the system. These three committees joined an existing committee, called the **Joint Standing Committee on Rural Issues** (JSC), focusing on health care issues in BC's less populous regions. Together the four committees became known as the **Joint Collaborative Committees** — or JCCs. Each one has four doctors and four government representatives, as well as health authority members.

FERTILE FIELD FOR COLLABORATION

These four committees have seeded unprecedented cooperative endeavours in BC, unique in all of Canada.

"There's a different focus now towards 'how can we do this together?' " said Dr. William Cavers, former president of Doctors of BC and a past co-chair of the GPSC.

Family physician leaders from across the Interior met on this fertile ground in 2013 with then-Deputy Minister of MCFD Stephen Brown (now Deputy Minister of Health). They discussed two family journey maps — one in Kamloops and one in North Okanagan — that identified serious barriers in accessing care and supports for children and youth with mental health and substance use issues. The idea of the Collaborative emerged as the way to tackle these gaps.

Tregillus credits Brown for embracing the unusual Collaborative structure. "If he had not held the space for this disruptive mechanism — which is set apart from, but supported by, government —we would not exist," explained Tregillus.

The Shared Care Committee, co-chaired by Dr. Gordon Hoag and government representative Marilyn Copes, is the primary funding partner, with the other three committees providing considerable additional support. Shared Care has become the "backbone organization" for the CYMHSU Collaborative, meeting one of the requirements of a **Collective Impact** model of change.

A MADE-IN-BC MODEL OF CHANGE

How do you change complex systems like health and social services? Some have likened it to changing a 747 engine in flight.

Almost three decades ago the US Institute for Healthcare Improvement (IHI) took on that challenge and devised a change model that features local teams committing to address a specific problem, guided by a steering committee and advisory faculty of experts. Teams work on the problem during an action period of three to six months, then convene together in Learning Sessions to share results, learn from mistakes, and commit to a new round of activities. IHI collaborative models are now very common in health care systems around the globe and are being applied to everything from surgical site infections and cancer treatment to physician burnout and patient safety (see IHI.org).

When the Collaborative started with eight Local Action Teams in the Interior, it adopted the IHI model. But as it expanded it became clear that another change model, called Collective Impact, also applied.

First described in 2011, Collective Impact is a new approach to highly complex problems where the answers are not completely known, and no single entity has the resources or the authority to bring about all the necessary changes. Collective Impact emphasizes building cross-sector relationships and changing how organizations work together, rather than just focusing on specific projects, which organizations participate in, or on achieving end goals.

Five conditions denote a Collective Impact initiative: a common agenda; shared measurement systems; mutually reinforcing activities; continuous communication; and a backbone support organization that coordinates activities. Collective Impact is now being applied globally to difficult social challenges like poverty, environmental clean-up, and homelessness.

"The CYMHSU Collaborative has evolved into a unique hybrid of both the IHI model and the Collective Impact model," said Christina Southey, CYMHSU Provincial Collaborative Coach.

LEARNING SESSIONS

Participants at Learning Session 8 were up on their feet dancing to the Indigenous songs of the Nahanee Family at the opening plenary.

CONVENING REGULARLY TO LEARN FROM EACH OTHER

Every six months or so, Collaborative members have come together in a large conference setting to share results and learn from each other. Called Learning Sessions, these highly inspiring, two-day events are a time to network, share ideas and information, and help spread the work of the Collaborative.

The first four Learning Sessions took place in Kelowna between June 2013 and October 2014, when the Collaborative was still primarily centred in the Interior, and featured up to 250 attendees.

As the Collaborative grew, the Learning Sessions were moved to Vancouver in April 2015, where they have been held in the large conference space of the Sheraton Wall Centre. Learning Sessions Five through Eight have each welcomed up to 600 people.

A defining feature of all Learning Sessions has been the presence of youth and families with lived experience who have bravely shared their journeys, their struggles and triumphs, and their hopes and ideas for a transformed system. Preparing and coaching youth and families to be able to feel safe and protected to speak in front of large audiences has been the careful and compassionate work of the Institute of Families/FORCE.

Post-event evaluations of all the Learning Sessions to date have repeatedly found that the presentations from youth and families have been among the highest rated portions of the two days. Evaluations also have consistently shown that the vast majority of participants found the Learning Sessions to be inspiring, informative and relevant to their work.

THE COLLABORATIVE STRUCTURE

A COMPLEX STRUCTURE FOR A COMPLEX UNDERTAKING

Describing the Collaborative to newcomers is a challenge: there are so many parts. Each component, below and on the facing page, plays a key role in the Collaborative, from the level of community-based Local Action Teams, to the regional offices of chief executives in the health authorities, to the deputy ministers in government where provincial policies are made.

THE CORE COMPONENTS

DOCTORS OF BC & THE BC GOVERNMENT:

The chief stewards of the Collaborative, Doctors of BC leads the administration and logistics while deputy ministers and other executives from four government ministries —Health, Education, Children and Family Development, and Social Development and Innovation — take part.

THE JCC:

The four Joint Collaborative Committees, with representatives from Doctors of BC and the Ministry of Health, fund quality improvement projects out of the Physician Master Agreement. The Collaborative is one of its biggest projects to date. Two other committees (GP Services, Specialist Services) have contributed funds, but the Shared Care Committee is the major funder and backbone organization for the Collaborative.

MENTAL HEALTH & SUBSTANCE USE CLINICAL FACULTIES:

Each clinical faculty consists of provincial experts in mental health and substance use care and delivery. The Mental Health Faculty has 30 members and the SU Faculty has 28. Both provide advice, and review and support the work of the Steering Committee, LATs and working groups.

STEERING COMMITTEE:

Its 40 members, including four youth, meet monthly by telecon. Members include representatives from Doctors of BC, Ministries of Health, Children and Family Development, the health regions, the Regional Initiative Leads, Institute of Families/FORCE, the Canadian Mental Health Association (CMHA), the RCMP, as well as physicians, school counsellors and the leadership team. It oversees the work of the Collaborative.

WORKING GROUPS:

Formed to tackle barriers to coordinated, effective CYMHSU care too big for LATs, the 11 working groups have subject-matter experts and stakeholders who study the problems, make recommendations, and draft protocols and guidelines to find solutions.

LEADERSHIP TEAM:

A Provincial Collaborative Coach and five regional Collaborative Coaches provide support, resources, tools, and information to the LATs. Five Regional Initiative Leads (RILs) advance CYMHSU priorities at regional tables. The RILs are employed by Shared Care and work on LAT budgets. They collaborate with Divisions of Family Practice or CMHA, who act as fiscal hosts for individual LATs. The Leadership Team includes the Coaches, RILs, the head of Institute of Families/ FORCE, and the Director and Coordinator of the Collaborative. The Shared Care senior project coordinator, and representation from MCFD, Ministry of Health, and the Canadian Mental Health Association round out the team. The leadership team meets weekly to manage the day-to-day operations of the Collaborative.

LOCAL ACTION TEAMS:

Each LAT aims to bring to the table a wide cross section of mental health service providers (physicians, CYMH-MCFD, school counsellors, community agencies, health authorities), First Nations, RCMP and first responders, and especially family and youth with lived experience. Focusing on quality improvement projects, mental health literacy, access, and community engagement activities, LAT membership varies from a dozen people to more than 100 in some communities.

LOCAL ACTION TEAMS SPREAD COLLABORATION & CARE

When physicians and service providers in the BC Interior got together in 2013 to learn about and discuss gaps in care for kids with mental health challenges, no one could have imagined the result would be 64 Local Action Teams based in Northern, Coastal, Interior, Lower Mainland and Island communities. Starting with eight original LATs in the Interior in June 2013, the Collaborative grew in one region after another, to reach its full complement of 64 teams by December 2015.

Early in its evolution — and thanks to the work of a team representing Doctors of BC, MCFD and Ministry of Health, seven Divisions of Family Practice, and Interior Health — a Charter was developed that would serve as an orientation guide for LATs. While the Charter set out clear aims and rules of engagement, it gave complete flexibility to community stakeholders and youth and families with lived experience to identify gaps and needs and develop solutions that were tailored to the unique strengths and capacity issues of their communities.

"Instead of coming in and saying 'do XYZ' to LATs, we said 'Here are some objectives, do they resonate with you, what is it that you would like to work on?' and 'How can we support you in that?" noted Christina Southey, Provincial Collaborative Coach about the approach to LAT engagement. "I think we created more engagement because people could find themselves within that structure. We weren't coming in and imposing projects on communities we didn't know."

Each LAT began in much the same way: identifying key stakeholder groups, inviting professionals to become part of the Collaborative, and in many cases working closely with The FORCE Society for Kids' Mental Health to engage youth and parents with lived experience on the team. Bringing the right people to the table and, as importantly, the right organizations was an initial priority. Almost all LATs have experienced some turnover of participants, and recruiting new members, building and maintaining relationships has been vital to their success.

Following the lead of other LATs and working with their Coaches and Regional Initiative Leads, each LAT engaged in local priority setting within the context of eight objectives that were set out in the Charter. All eight objectives aimed to improve timely access to integrated services and ensure the full engagement of youth and families in decision-making related to their care. Many LATs embarked on "journey mapping" exercises early in their development to document the way in which local youth and families moved through the child and youth mental health and substance use systems of care in their region. The experience of being part of a journey mapping exercise was transformational for many LAT members. From there, LATs moved to the stage of developing their own local charter, which set the course for exploring and testing collaborative ways of addressing gaps that had been identified.

As will be illustrated in the follow pages, LATs engaged in a wide variety of activities: working with schools to strengthen their capacity to understand and address child and youth mental health issues in the classroom; holding public events to increase mental health literacy; training professionals in suicide intervention or communities in mental health first aid; surveying specific populations to discern mental health knowledge and needs; and many more local priorities.

In short, all across the province, LATs are building a strong network of grassroots relationships to improve mental health and substance use care for children, youth and families in BC.

Vancouver Island

34 Campbell River
35 Comox
36 Cowichan
37 Gabriola
38 Long Beach
39 Mount Waddington
40 Nanaimo
41 Oceanside/Parksville
42 Port Alberni
43 Saanich Peninsula
44 Salt Spring Island
45 Sooke/West Shore
46 Victoria

Fraser

47 Abbotsford
48 Burnaby
49 Chilliwack
50 Delta
51 Fraser Cascades
52 Langley
53 Mission
54 New Westminster
55 Ridge Meadows
56 Surrey/North Delta
57 Tri-Cities
58 White Rock/South Surrey

KNOWLEDGE *IS* POWER

IMPROVING LITERACY, SKILLS AND ATTITUDES AROUND MENTAL HEALTH

More than 100 people came out to ***Shuswap LAT's*** *Lantern Walk for suicide prevention in September 2016. Photo: Sarah Lauzé*

One way to improve mental health and substance use outcomes for BC children and youth is to develop the public's mental health literacy. This is defined as having four key components:

- **Understanding how to optimize and maintain good mental health**
- **Understanding mental disorders and their treatments**
- **Decreasing stigma**
- **Enhancing help-seeking skills — knowing when, where, and how to get the right help.**

Since the Collaborative's start, almost all LATs have engaged in mental health literacy activities in their communities, sometimes holding multiple events. In fact, out of 64 LATs, **268 mental health literacy activities** were held across the province since March 2015. These ranged widely, and included:

- public forums or presentations in communities on topics like anxiety, depression, suicide awareness and the fentanyl crisis;
- guest columns on mental health and substance use topics in local newspapers;
- school-focused activities like plays, presentations and a specific mental health curriculum;
- stigma-reducing events with mental health themes from comedy and poetry nights, to art shows and hockey games that raised awareness and connected individuals to local resources;
- barbecues, dinners and other community engagement activities to link individuals and raise awareness;
- creating posters, pamphlets, bookmarks, postcards, bracelets, colouring books and other products to raise awareness, improve mental wellness, reduce stigma and link to local resources.

The following pages highlight some of the diverse range of mental health and substance use literacy activities by LATs under the Collaborative umbrella.

PUBLIC RESPONDS TO INFORMATIONAL FORUMS ALL OVER BC

When the **North Okanagan LAT** held a forum on youth anxiety in Fall 2015, more than 350 parents showed up, looking for information and support for this common mental health concern that affects about one in five young people.

"We were amazed by the strong turnout," said Dave MacKenzie, a Vernon high school counsellor and one of the organizers. "It shows how eager parents are for information and support."

LATs held public information forums all over the province — usually to large turnouts of concerned parents and families. In fact, more than **45 educational events** were held in 2015/16 by 33 LATs on specific mental health and substance use concerns that, all told, thousands of youth and parents attended. The events typically feature speakers as experts, or a panel of experts, as well as families with lived experience. After the presentations, questions are taken from the audience. Information tables at the events link local residents to available services.

White Rock South Surrey LAT had hundreds of parents turn out to evening events: one each on anxiety, depression, and suicide awareness.

Central Okanagan LAT held an evening about fostering human resiliency when faced with life's challenges, with expert Nan Henderson, to which more than 240 youth and parents attended. The initiative also included a 2.5 day resiliency training workshop for school counsellors, teachers and community professionals.

Delta LAT first held a public forum in May 2016 on anxiety in children and youth to which 275 people showed. It was so successful the LAT co-sponsored a second October 2016 public forum, entitled "Depression and Suicide: It's Okay to Talk about it."

continued from previous page...

While the forums have most commonly focused on depression, anxiety, suicide and self-harm, the **Tri-Cities LAT** held a speaker series in 2016 not only on anxiety, but on ADHD and on gaming addictions, to which hundreds attended.

Other LATs focused on drug and alcohol addictions issues. The **Sunshine Coast LAT** held a series of cannabis panels for both students in school and parents, in which local experts talked in honest terms about the impact of the substance in all its various forms on the developing teen brain.

Ashcroft and **Revelstoke LATs** both hosted University of Victoria drug prevention expert Dan Reist, who co-chairs the Collaborative Substance Use Clinical Faculty. He spoke about "Rethinking Drug Education."

In 2016 as the opiod crisis deepened across the province, a number of LATs focused on fentanyl awareness events and harm reduction, such as the **Chilliwack LAT** and **Golden LAT**.

In October 2016, the **Langley LAT** hosted an educational evening about fentanyl at the Township of Langley Civic Facility, co-sponsored with the Langley School District, Langley RCMP, and Fraser Health. The community forum discussed what fentanyl is, how to detect it, and what to do in case of an overdose. More than 80 members of the public listened to the presentations and asked questions of the panelists, which included Langley youth advocate Corey Reid, RCMP officers, medical professionals, community workers, and other youth representatives.

All the public forums around BC reduced stigma, raised awareness and knowledge, and connected youth and parents to local professionals and to each other.

"If anyone went feeling isolated and alone, by the end of the evening they knew they were not alone anymore," remarked MacKenzie about the Vernon event, a sentiment which applied to all the forums across BC.

Langley Youth Advocate Corey Reid, who is also co-chair of the Langley LAT, speaks at the October 2016 Langley Fentanyl public forum. Photo: Miranda Gathercole, Langley Times

LANGLEY LAT USES MULTIPLE WAYS TO RAISE AWARENESS

As an example of a LAT that went all out raising mental health awareness in its community, look no further than the **Langley LAT**. With feedback and ideas from engaged youth reps, the LAT used the following methods, in addition to community forums, to connect with its wider community.

- **Two sets of self-help posters**: The LAT created four separate posters targeting four concerns: self-harm, sadness, worry, and stress. Each poster had signs, symptoms, and techniques to help as well as links to resources. More than 2,000 posters were distributed to schools, community organizations, public buildings, LAT member offices, and GP offices. Then, following the success of the first round of poster distribution, the LAT held a contest among youth to illustrate the same four poster themes. More than a dozen entries were received and four winners selected. The new posters, which were distributed in September 2016, contain the same information, but are illustrated with dramatic and moving youth artwork. The posters are now being offered province-wide.
- **Digital messaging**: Information about mental health issues was created that now plays on digital screens in 11 GP offices as well as community centres and organizations.
- **Mental Health Community Awareness Day**: A day-long fair in a local park was held in May 2016, with live music, speakers, information booths, food, yoga-in-the-park, a pledge wall, selfie station and links to local MHSU resources.

TEACHABLE MOMENTS:

MENTAL HEALTH LITERACY ACTIONS IN SCHOOLS

The school environment is a powerful and accessible way to target mental health literacy events, whether to children and teens, or to teachers and school staff. Across BC many LATs partnered with their local schools and school districts on a wide range of mental health and substance use activities. Collaborative LATs engaged in 96 school-based Mental Health Literacy initiatives that reached out to thousands of children and youth in BC, their families, and to the teachers and staff who interact with students each school day.

21 LATs held mental health and substance-use related informational events and forums in schools, such as plays, presentations, guest speaker series, World Cafe conversations, and health fairs.

16 LATs raised mental health literacy and awareness of resources by distributing information through schools to youth and families about mental health issues or resources on handy cards, magnets, posters, bookmarks, key messages in report cards, and more.

14 LATs held training sessions or workshops for youth in school to teach specific skills to help improve their own mental health or skills to help their friends with mental health issues, such as peer-to-peer listening, mentoring, and suicide prevention assistance.

16 LATs assisted teachers or school counsellors to access various training programs, Pro-D day workshops, or curriculum support to increase school staff skills and knowledge about mental health issues, substance use, and trauma.

→ NEW MENTAL HEALTH CURRICULUM FOR THE NORTH SHORE

This spring students in Grade 9 in all the public schools in West Vancouver and North Vancouver will have classroom time devoted to an evidence-based mental health literacy curriculum.

The initiative is the culmination of a year of work by the **North Shore LAT,** which brought multiple partners to the table, including the West Vancouver and North Vancouver School Districts.

"It is incredibly important to de-stigmatize the conversation about mental health and provide our youth with the tools to keep themselves well and equip them with the knowledge of where to seek help if they or their friends begin to develop a mental illness," said Jeremy Church, district principal with the North Vancouver School District and Co-Chair of the North Shore LAT.

The creation of the *Mental Health and High School Curriculum Guide* has been led by noted Canadian mental health expert Dr. Stan Kutcher in partnership with the Canadian Mental Health Association. The curriculum features six unique modules, as well as tests to evaluate students' learning. It has been delivered and successfully evaluated in a number of schools across Canada. This is the first time, however, that it will be delivered in BC schools. An estimated 2,000 Grade 9 students will get the new mental health training in the 10 high schools across the North Shore in the Spring of 2017.

In early December 2016, Dr. Kutcher came from Atlantic Canada to train more than 100 North Shore teachers and community partners in a two-day session. As well, he was the guest speaker at an evening forum attended by more than 400 people.

Dr. Kutcher also trained parents-in-residence from the Institute of Families/FORCE in the training session. The aim of the training is for the Institute, through the Collaborative, to hold ongoing mental health workshops to increase family mental health literacy.

Nova Scotia's Dr. Stan Kutcher came to BC in December 2016 to conduct training sessions for the new mental health curriculum.

FROM BOOK CLUBS & JOURNALING TO STAND-UP COMEDY & POETRY

LATs FIND MANY WAYS TO RAISE MENTAL HEALTH LITERACY

LATs showed tremendous originality in reaching out to their communities to raise awareness about mental health and substance use issues to create connections and foster caring adults:

Chilliwack LAT partnered with the Chilliwack Chiefs (BC Hockey League) and Canadian Mental Health Association, to sponsor a Mental Health Awareness Game Night in February 2016. Youth members of the LAT filmed a video with players, coaches, and service providers in the community to raise awareness about mental health issues, decrease stigma, and encourage youth to speak up and seek help. The video, which was played at the game and is also available on YouTube, highlighted services that are available for youth. Local service providers hosted booths at the hockey game.

Upper Skeena LAT supported Gitxsan matriarchs and youth to come together for three days in July while the sockeye salmon were running in the Skeena River. Together they processed fish and discussed what wellbeing looks like on Gitxsan territory, as well as how to put these ideas into practice. This gathering was a pilot approach to working with youth that is based on connection to themselves, to others, and to the land.

Fraser Cascades LAT sponsored an outing in August 2016, in which youth from Chawathil and Shxw'ow'hamel First Nations and from Hope travelled with two members of the LAT to meet Dr. Jennifer Mervyn on the water in White Rock. The day-long event included circle sharing, photo-journaling, paddle-boarding, and discussions on what youth in Hope needed for better mental health. Some of the youth had never seen the ocean before. They faced anxieties about new experiences, formed connections, and discussed the importance of balance in life, Mervyn noted.

Terrace LAT held a Youth Art Collaborative event in July to raise awareness about mental health and substance use, asking local children and youth to depict what wellness means to them. About 150 youth participated, some submitting stories, poems and drawings. Local agencies like MCFD, First Nations, Northern Health, the RCMP, yoga providers, and more provided information booths.

Mt. Waddington LAT, which covers Port Hardy, Port McNeill and other northern Vancouver Island communities, created a book club in which local teens read and discuss young adult novels with mental health themes. In the fall, 10 vulnerable teen-aged girls were reading and discussing novels like *Perks of Being a Wallflower*, the coming-of-age story of a sensitive youth.

Port Alberni LAT co-sponsored with School District 70 a two-day substance use awareness event for Grade 7 & 8 students. Called YES2KNOW, the provincial RCMP-led initiative is tailored to community needs, discusses making positive and healthy lifestyle choices, and increases education on drug and alcohol issues.

Valemount LAT held a "Stand up for Mental Health" comedy evening in June 2016 to reduce stigma and increase resiliency regarding mental health issues. The LAT also entered a mental-health-themed float in the annual Valemountain Parade, winning third prize. In December, the LAT held a free Skate with the RCMP and had a mental health awareness table to inform participants of local resources.

Surrey/North Delta LAT: On August 15th, 2016, 40 youth with lived experience from communities stretching from Burnaby to Hope attended a day-long Fraser Youth Networking Event. Among the many activities was a "Bricks and Barriers" exercise, in which the youth wrote on post-it note "bricks" some of the barriers they had experienced trying to access services. The youth also held table discussions and created a polaroid photo guestbook. While Surrey/North Delta was the major sponsor, LATs from Abbotsford, Burnaby, Chilliwack, Fraser Cascades, Langley, and White Rock South Surrey also contributed.

Golden LAT held a Poetry Flow evening in May 2016 aimed at reducing MH stigma through poetry and music. Held at a local coffee shop, it fostered expression, inspiration and strengthening of community connections.

Kitimat LAT held a community dinner, called Honouring Youth and Families, to which more than 300 people attended. The guest speaker was Mike Scott, from Sturgeon Lake First Nations in Saskatchewan, who shared his inspiring, hopeful journey from near death and addictions to crystal meth and alcohol in his teens, to his new life embracing sobriety with his "Sober is Sexi" campaign. He travels the world as a motivational speaker, particularly to Indigenous communities.

Vancouver LAT has identified a specific neighborhood, Victoria-Fraserview, where it is focusing its MH literacy events and awareness raising activities. Improving communication between youth, families and service providers, creating an inventory of services, and holding a public forum on anxiety are some of the activities it has planned for 2017.

PUPPETS PROMOTE GREATER UNDERSTANDING

"A sensitive message is way easier with a puppet," says puppeteer/ventriloquist Heather Megchelsen, who is the family educator for the BC Schizophrenia Society in the Burns Lake-Omineca Lakes District and a member of the **Burns Lake LAT**.

Sponsored by the LAT, Megchelsen worked with four Burns Lake high school students, whom she taught to be puppeteers. Together they rehearsed *How to be a Friend*, a puppet play about psychosis and schizophrenia. The play has four Muppet-like characters: a young man experiencing breaks from reality, his sister, and two friends. It follows his changes in behaviour, his realization he needs help, and his return from the hospital after successful treatment — and how his sister and friends learn how to give him the friendship and support he needs.

Megchelsen and the teens presented the show three times to more than 180 children between Grades 4 and 7 in the three Burns Lake local elementary schools. "It is cool for the high school kids as they are teaching the younger kids, but they are learning at the same time," said Megchelsen, who played the mother and narrator.

Heather Megchelsen with one of her puppets.
Photo: Carla Lewis

While first psychotic breaks typically arise in mid-teens to early adulthood, raising awareness about psychosis, even among younger children, "helps normalize the conversation," said Megchelsen. Moreover, many teens will keep symptoms quiet or delay seeking treatment for months or even years, although early intervention is important. Research studies, including a new, large 2016 UK study of more than 3,600 patients, have found that early psychosis intervention programs create much better health and social outcomes for youth and greatly reduce costs for families and society.

SCREENAGERS:
TOO MUCH SCREEN TIME HARMS YOUNG BRAINS

How much time do you spend on your smart phone? Many are shocked to learn it is much longer than they think.

That was a common response from hundreds of youth and parents across BC who have attended LAT-sponsored viewings of *Screenagers*, a new documentary about social media, video game use, and internet addiction — and its impact on mental health.

Screenagers is a sobering examination of the impact of screen technology on the teenage brain that has been shown by five LATs. **Saanich Peninsula LAT, Sooke/West Shore LAT,** and **Burns Lake LAT** held showings with Q&A follow-up in November 2016, drawing between 100 and 250 people each time.

"Our event was so well received that we are doing more screenings," said Nicole Rushton, project lead of the Burns Lake LAT. The LAT plans to show the movie to all 360 youth in the local high school as well as to Grades 4 to 7 at the elementary schools. **Fraser Cascades LAT** and **Chilliwack LAT** sponsored screenings in Hope, Agassiz and Chilliwack in late 2016 and early 2017.

The film covers the social pressure for kids to have smart phones and the difficulty parents and youth have monitoring and setting limits on their use. In it, brain scientists show how we are hardwired to seek and experience pleasure when our texts are returned or when we are rewarded in a game. The release of the neurotransmitter dopamine into the pleasure centre of the brain makes us want to repeat the activity endlessly. The film stresses that families must be informed about the advantages and disadvantages of technology, set boundaries, and talk openly about how social media and gaming addict our brains and undermine our connections.

One male youth in the film becomes so addicted he eventually is admitted to a rehabilitation facility. Technology use also undermines self-esteem, with girls as young as 11 in the film admitting to photo-shopping their pictures to appear more attractive on social media.

Post-film discussions always hit close to home, including how parents, too, succumb to the addictive lure.

ASKING THE RIGHT QUESTIONS

LATs CONDUCTED SURVEYS TO ASSESS COMMUNITY KNOWLEDGE AND NEEDS

ALBERT EINSTEIN once said that if he had 20 days to solve a problem, he would spend 19 days defining it. His point: if you want to find the right solution, sometimes you have to spend time asking the right questions.

Over the last few years, more than 30 LATs around the province applied that principal to their own regions and spent time creating and executing surveys among their key populations to better understand their concerns, knowledge and needs around child and youth mental health and substance use issues.

SURVEYING STUDENTS

Asking youth about their mental health concerns, conducting short screens for depression and anxiety, and asking them what they wanted or needed in their community to help address their needs was a focus of half a dozen LATs. **Dawson Creek LAT** led a survey of 476 youth in the high schools to determine what youth wanted to see in their community. **Lillooet LAT** surveyed their high school students, with an 80% return, to assess gaps in understanding and services around MHSU care and to find out what teens felt they needed and how they might engage with the LAT. **Pemberton LAT** surveyed 92 students about MHSU concerns. In **Bella Coola** three teens, supported by the LAT, created, delivered and analysed a survey of the entire Grade 6 to 12 school population — more than 150 students —in the two high schools and got an astonishing 100% return. Now the LAT is using the results to better tailor actions to the youths' responses.

SURVEYING THE COMMUNITY

Taking advantage of gatherings at community events such as information sessions, community barbecues, youth festivals and fairs, five LATs asked those gathered to fill out surveys about MHSU knowledge and needs. Other LATs used online portals, or in-person surveyors to ask specific questions. **Ridge Meadows LAT** used an online survey to reach more than 500 parents and youth. **Abbotsford LAT** co-sponsored the survey of 204 South Asian parents, see story next page.

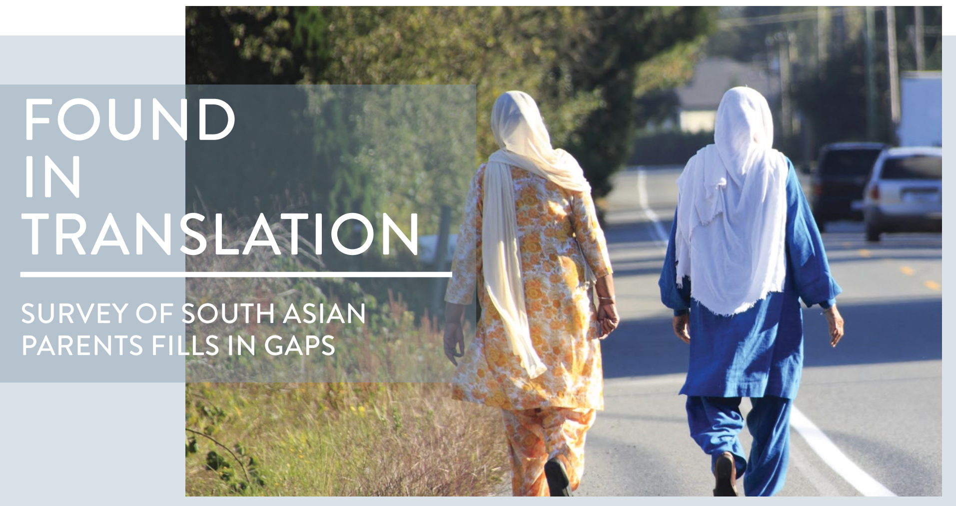
SURVEYING LOCAL PROVIDERS

The needs and knowledge of health and service providers in their communities was the focus of four LATs' surveys. **Long Beach LAT**, for example, distributed a "Priority Setting Survey" to members of government agencies, RCMP, First Nations Tribal Councils and Health Authority, physicians, the school district, community agencies and other stakeholders to assess their feedback on child and youth mental health and substance use needs.

SURVEYING PROVIDERS AND THE COMMUNITY

Gathering information about both providers' and the community's knowledge and use of a local resource directory was the focus of a survey co-sponsored by the **Upper Skeena LAT**. Similarly **Mt. Waddington LAT** surveyed both service providers and families about knowledge of existing CYMHSU services.

The Collaborative was invited to consult with the McCreary Centre Society on the mental health and substance use questions that will be used as part of their 2018 Adolescent Health Survey.



FOUND IN TRANSLATION

SURVEY OF SOUTH ASIAN PARENTS FILLS IN GAPS

The region around Abbotsford is home to close to 30,000 people of South Asian heritage and according to Statistics Canada, has the highest per-capita density of Sikhs in the country. So in 2016, when the **Abbotsford LAT** was discussing ways to connect with its wider community, they wondered what the South Asian population knew about child and youth mental health and substance use. What worried them? Did they know where to get help?

"We realized we were lacking information about the needs and understandings of a key part of our community," said Palwinder Kelay, Program Manager, Multicultural Department, of Abbotsford Community Services (ACS), an active LAT member since its inception in 2015. The LAT has members from more than a dozen organizations as well as youth and parents.

As a community social service agency, ACS has many programs designed to help new immigrants adjust and thrive. The ACS also has the relationships and linguistic ability to conduct a survey in Punjabi about child and youth mental health concerns.

"It had to be a one-on-one conversation to have them comfortable with us asking questions," said Kelay, who notes that mental health stigma, while a concern among all Canadians, tends to be even greater among new immigrants. "There is a lot of fear and misunderstanding — it is taboo among some parents. That can make it even harder for kids to get help. We wanted to help normalize the conversation."

ANSWERS SPUR RESOURCES

In August and September of 2016, Kelay and a team translated seven survey questions into Punjabi and went to the local temples, parks, grocery stores, and other places they knew to be popular with the community. They received permission to be on school property to ask questions to parents dropping off and picking up their children. They also surveyed parents at ACS events, ultimately surveying more than 200 parents in Punjabi.

The results found that most (73%) were sometimes or currently worried about their child's mental health and well over half (62%) were currently worried or sometimes worried about the child using drugs or alcohol. The majority of those who were worried said they did not have the information they needed to help their child and that they would like to get mental health information from a community information event. They also welcomed the idea of a health clinic where children and youth could get MHSU care even if they were not with their parents.

"It's a tight-knit community, so it was really great to see how open they were to getting more information and to have their children get the help and support they need," said Kelay.

An immediate result of the survey is that a resource sheet of community mental health and substance use services has been translated into Punjabi, is being distributed in the community, and has been published in the local Punjabi newspaper.

The survey results are also now being used by the Abbotsford LAT to create new events early in 2017 to meet the mental health concerns of the South Asian parents and youth, notes Danielle Edwards, LAT project lead.

COUNTING CARING CONNECTIONS

HOW DO YOU KNOW if enough caring, supportive adults are in the lives of children in your community? You ask them. The **Ashcroft LAT** members did just that. With teen helpers, LAT members visited Cache Creek Elementary School and Desert Sands Community School and surveyed 380 children and youth in Grades K to12. The survey asked students to finish the sentence, "I know you care about me when …". Answers were put on green post-it notes that went up on a large white banner in school hallways.

Students were also asked how many caring adults were in their lives. Teen helpers worked with younger children to fill in the answers and collect results. A draw rewarded students with prizes like yoga mats and colouring books.

Most of the students said they knew they were cared for when they were hugged or cuddled, listened to and talked to, and when people told them they loved them. While some students felt cared for when they were given snacks or meals, few said caring had anything to do with having things bought for them. The LAT found that most students had four or more caring adults in their lives, but a few children had three or less.

"We were especially concerned about the students who felt they had only one, or even no, caring adult in their lives", said LAT Co-chair Trish Schachtl, who is also a child and youth care worker at Desert Sands.

The results led to a discussion at the LAT table and with school principals. The principals, in turn, shared the findings with staff as part on their ongoing focus on student connectedness, using the information to build supports for vulnerable students.

11 TIPS TO STRENGTHEN YOUTH & FAMILY ENGAGEMENT

DURING THE COLLABORATIVE, it became clear that the involvement of youth and families with lived experience is essential if the system is to improve. While easy to recognise and to say, engagement with youth and families requires time, effort, knowledge and skills. It can be hard to do until these come together. That was the conclusion of the 26-member youth, young adult and family evaluation team (YYAFET).

"Inclusion is not just about being together, it is about deliberately planning for the success of all," said Allison Zaporozan, a parent member of YYAFET. "There are professional experts and family experts, both bring valuable things to the table."

"When it's an open, receptive, safe, and respectful relationship between the two, change can and does take place," notes Zaporozan who is also a member of **Fort St. James LAT.**

In 2016, the team surveyed levels of engagement on the 64 LATs and in their analysis developed the following 11 tips for doing it well.

1 DISCUSS VIEWS AND VALUES

Review and discuss LAT members' views about youth and family engagement. Do LAT members believe that youth and families with lived experience should be at the centre of all processes that affect the health and mental health of children and youth? How do LATs' actions reflect "youth and families at the centre"? Do team values need to shift? Discuss ways that people can be safe in sharing their thoughts and suggestions.

2 DEFINE ROLES

Ensure the LAT is clear on why it is important to have youth and family members with lived experience on the LAT. Discuss how youth and family members will guide and co-develop objectives. Discuss all LAT members' purpose and roles. This is especially important for youth and parents.

3 WRITE AGREEMENTS

Develop written agreements about what needs to happen for youth and family members to participate fully and safely in each LAT. Ask what should be in the agreements to have them feel safe.

4 RECRUIT TOGETHER

Work collectively to recruit youth and family members with lived experience. Look to local support groups, advocacy groups and those with known interests in building a better child and youth mental health and substance use system.

5 MODEL ENGAGEMENT

Ensure Team Leaders and co-chairs model good processes for youth and family engagement. Are one or more LAT members also able to champion this cause?

6 EQUALIZE PARTICIPATION

Help youth and family members feel equal on the LAT. For example, hand out orange cards to all LAT members that can be raised when jargon is used at meetings.

7 MAKE TIME

Provide time in each agenda for youth and family to share their observations, experiences, or their stories. Co-develop agendas ahead of time and get youth and family input. If there's not enough time, examine why. Also plan how to support them in their sharing, and how to debrief challenging experiences.

8 USE INPUT

When input is provided, incorporate it into the LAT activities and encourage the involvement of youth and families in the co-development of LAT products.

9 VALUE PRESENCE

Acknowledge the amazing, brave youth and family members who attend LAT meetings and are engaged in Working Groups. Demonstrate that they are integral to the team. Schedule meetings around youth and family members' schedules.

10 SHARE JOURNEYS

Share your own family experiences with child and youth mental health and substance use. This helps reduce the isolation felt by youth and family members.

11 MONITOR AND CORRECT

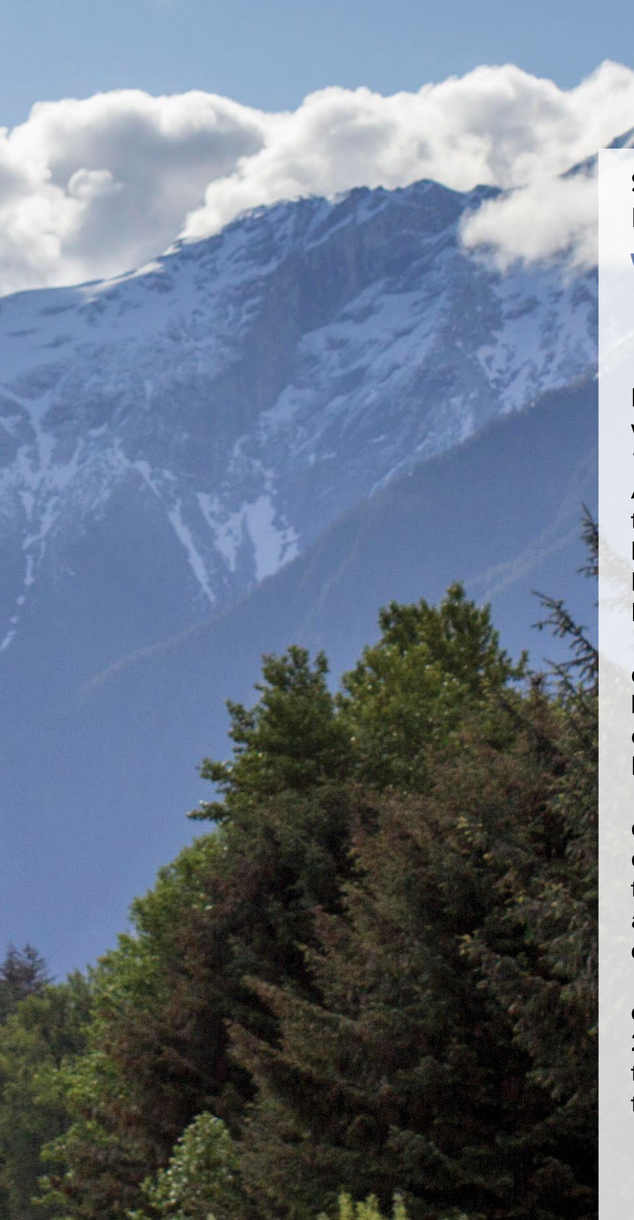
Track your progress. Who is staying, and who is leaving the team, and why? Address issues safely and respectfully.

The 26-member YYAFET consists of representatives from the Institute of Families/ FORCE, the Collaborative's Evaluation Working Group, and nine youth and 13 parents or grandparents with lived experience.

On a trip to Bella Coola to support its LAT, Collaborative Coach Christina Clarke took this photo of the village's Sputc totem pole, which honours the return of the eulachon fish each spring.

FIRST NATIONS PERSPECTIVES

Indigenous youth in Canada face a unique set of mental health challenges. The Collaborative has 201 members who belong to First Nations organizations. A number of LATs engaged in activities to increase cultural sensitivity.



SPREADING ONLINE PROGRAM TO HELP IMPROVE CARE FOR INDIGENOUS PATIENTS

When Prince George pediatrician Dr. Marie Hay took the online Indigenous Cultural Safety training program a few years ago, her life changed.

"It profoundly moved me and changed me not only as an individual but also as a professional — it changed the way I practice," said Hay, who trained in Dublin and the UK, but has been in Prince George since 1990. She estimates that 50% of her young clients are First Nations. After the course she now takes more time to get to know her patients, to understand their backgrounds and lives, and to make a more knowledgeable connection, all of which, she feels, contributes to much better care. "People need to know and feel they are cared about and loved."

A year ago, when the **Prince George LAT** formed, Hay strongly encouraged other members on the team to take the San'yas Indigenous Cultural Safety (ICS) training program, which is offered online through the Provincial Health Services Authority. "I firmly believe as many people as possible should take it," she said.

So this past year more than half her LAT — 29 people— took the eight-week course. The LAT funded spots for 20 and nine more were eligible to take it through their employer. Hay is certain that the training will improve the region's mental health care for children and youth. "It opens whole new dimensions of compassion and connection."

Four other LATs have also provided members with the opportunity to complete the San'yas ICS training programs. **Prince Rupert LAT** funded 20 members, **Mt.Waddington LAT** enabled six physicians to get the training and both the **North Shore LAT** and the **Sea-to-Sky LAT** offered the program to more than a dozen of their members.

Continued next page...

PROGRAM FIGHTS STEREOTYPES

Created in response to the Transformative Change Accord of 2005, the ICS program curriculum began being offered online in 2008 through PHSA. (It changed its name from the Indigenous Cultural Competency (ICC) program to ICS in 2015.) The facilitated, interactive program is designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work with Indigenous people, and to promote positive partnerships.

Of the four main ICS programs, the majority of LAT members took the "ICS CORE Health" or the "ICS CORE Mental Health" programs, both of which are particularly appropriate for health care and mental health professionals working with Indigenous people.

The curriculum examines culture, stereotyping, the consequences and legacies of colonization, and contexts for understanding social disparities and inequities. Participants also learn how to develop communication and relationship-building skills.

The San'yas ICS program is free to those who work for a health authority, a First Nations organization or a BC government ministry, but for physicians and community agencies, and other LAT members its costs $250 per person. The program typically takes eight hours over eight weeks, with new programs starting weekly. Doctors who take the course are eligible for self-directed continuing medical education credits.

"It's a great program. I would recommend it to everyone," says Christina Clarke, Collaborative Coach for the Vancouver Coastal teams, who encourages other LATs in the CYMHSU Collaborative to consider completing the program.

For more information about the various programs see sanyas.ca

Prince George pediatrician Dr. Marie Hay says the online San'yas ICS training profoundly changed her. Photo: Philomena Hughes.

During the Blanket Exercise, participants are forced off blankets or have them taken away, recreating the experience of Indigenous peoples. Photo: Kate Baldrey

BLANKETS AS LAND

A SIMPLE EXERCISE OPENS HEARTS AND MINDS TO THE ONGOING HARM OF COLONIZATION

IN THE BASEMENT AUDITORIUM of Queen Alexandra Hospital in Victoria BC one hot August day, more than 30 people stand shoeless on blankets they have brought from home. The blankets are spread across the linoleum floor in a patchwork of bright colours. They represent "Turtle Island" — the First Nations name for Canada — at the time of first contact with European colonizers. Those standing on the blankets represent the Indigenous peoples.

"Everyone holding a white card, please step off the blankets and go sit down. You represent the thousands of Indigenous people who died from small pox and other diseases brought by the colonizers," says Yvette Ringham-Cowan, Facilitator of Cultural Safety for Island Health, who is co-leading the exercise on this day. More than half the group step off the blankets to sit in the chairs around the circle. This gut punch to all those present shows just how devastating infectious disease was to the First Nations. "Research shows that infectious disease caused the loss of between 50 to 90% of various First Nations populations," says Ringham-Cowan.

Over the next hour, participants are taken through Canada's history from a First Nation's perspective: colonization, treaties, the *Indian Act*, BC's lack of treaties and more. Blankets are taken away, the people who remain are forced onto other blankets that have been folded into tiny squares, representing the creation of reserves and the displacement of populations from their traditional lands. Others die of malnutrition or lose their status and

WEAVING GENERATIONAL CONNECTIONS — AND ARTFUL SKILLS — WITH CEDAR BARK

IT'S A THURSDAY AFTERNOON at the Adult Day Program, a drop-in-centre for elders in the First Nations community of Old Masset at the northern tip of Haida Gwaii. A half a dozen people of all ages surround a table covered in an oil-skin cloth. On the table, a plastic container holds brown strips of cedar bark soaking in water.

Those present laugh and talk as their hands, some more nimble than others, weave the cedar strips into attractive bracelets and roses.

"You got to pinch it really, really tight so it doesn't lose its shape," said one elder, demonstrating how to make a perfect cedar rose to the others, who try to imitate the movements.

"This is hard! But it is cool to learn," said one youth, Destiny Davidson, age 15, a Grade 10 student at Gudangaay Tlaats'gaa Naay Secondary School, who is a youth rep on the **Haida Gwaii North LAT**.

For generations, cedar bark has held a revered place in Haida culture. Known as the "elder sister," it is made into baskets, clothing, hats, rope, mats, jewellery, and other objects. Considerable skill is needed to harvest, prepare, and weave cedar bark and Haida elders are eager to teach these skills to younger generations.

Weaving also connects caring adults with First Nations youth, who, due to intergenerational trauma and colonization, have higher rates of mental health issues and suicide than other youth in Canada.

"Part of the health and healing for Aboriginal people comes from taking pride in who we are and in learning our skills and history," says Sandra Dan, a former addictions counsellor in Old Masset and the co-chair of the Haida Gwaii North LAT.

The regular weaving, sponsored by the LAT, not only links youth and elders, it raises awareness about mental health issues and raises funds for the LAT. The beautiful bracelets and roses are sold at Learning Sessions and auctioned in the local community.

Below: Sandra Dan, Destiny Davidson and Jaden Reinhardt of the Haida Gwaii North LAT weave cedar roses. Photos: Anne Mullens

are required to leave their blankets, to live away from their communities. Still others are taken away to residential schools and return home to unknown families, broken and disconnected from their cultures and their past.

At its conclusion, with facilitation by First Nations representatives, people now sitting in the circle of chairs share their experiences of being forced off the blankets or having their blankets taken away.

A VISCERAL EXPERIENCE

"It was such a powerful, emotional, experience. Many of us were in tears at the end. It inspired so much compassion and understanding for the generations of trauma that still impact First Nations," said Jenn Harrison of the **Sooke/West Shore** and the **Saanich Peninsula LATs.**

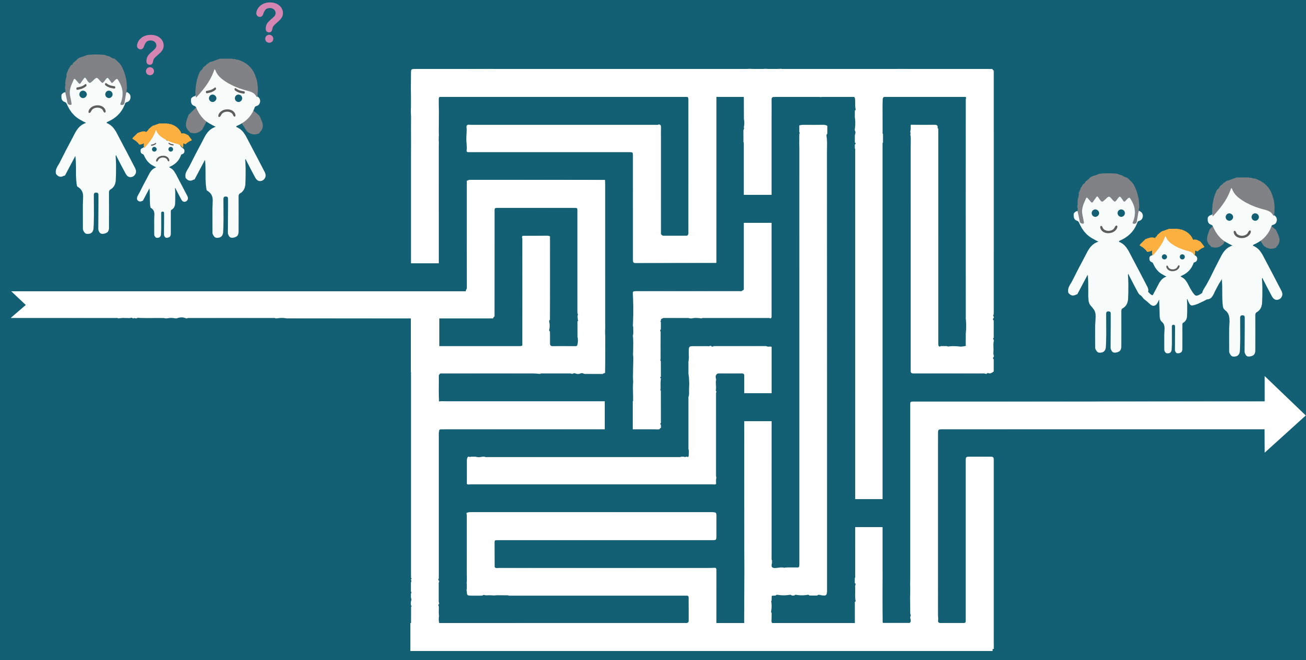
In 2016 four LATs in the Collaborative took part in the Blanket Exercise as one way to increase cultural understanding with Indigenous partners and foster cross-cultural engagement. Along with Sooke/West Shore and Saanich Peninsula, other LATs were **Salt Spring Island LAT** and **Victoria LAT.** Created by the multi-denominational ecumenical justice organization KAIROS about 15 years ago, the Blanket Exercise has been increasingly offered across Canada as a way to experience how colonization affected the first peoples. BC has its own script that facilitators use to align the exercise to what happened to the Indigenous population here over the province's history.

"We find the exercise really increases the depth of compassion and understanding and promotes healing and reconciliation in its own right," says Jon Rabenek, Coast Salish community engagement coordinator for the First Nations Health Authority, which co-sponsored the exercise with the LATs and Island Health.

Many mental health issues have intergenerational trauma as a pre-disposing factor. LATs who take part in the exercise find that the increased understanding of First Nations' trauma helps create a path to more shared goals and objectives. And it helps foster better mental health awareness and literacy that takes First Nations' experiences into account.

ACTIONS *FOR* ACCESS

HOW LATs HELPED FAMILIES THROUGH THE MAZE OF ACCESSING TIMELY & EFFECTIVE CARE



ONE OF THE KEY GOALS of the CYMHSU Collaborative has been to improve timely access to child and youth mental health and substance use care. Improving access, however, has many facets. Do youth and families struggle for access because they don't know when, where, and how to seek help? Many LATs chose activities to address this issue, creating websites, resource directories, wallet cards, rack cards, and other products that put information of who to call and where to go right into the hands of youth and families.

Sometimes the way to increase access is to train, support, or better equip the people they might turn to for help — whether it is a peer, a physician, a teacher, a front-line worker, or a community agency — so that those responders are better able to provide the right care.

Improving access can also come from creating new types of services or new locations for service delivery, such as a new type of clinic, or new clinic location at a school or a youth hub.

Since 2013 these and other activities have been undertaken by LATs across the province. In fact, since March 2015, a total of **366 activities** under the Collaborative could be classified as actions or initiatives to improve access. These include, but are not limited to:

22 WEBSITES:
The websites list regional agencies, phone numbers, and contact information as well as provide community information and links to helpful resources and/or supports. Facebook and Instagram pages were created by 16 LATs, and regular postings keep followers updated on events, important meetings, and shared information. For example **Kitimat LAT, Shuswap LAT, Sea-to-Sky LAT** and **Mt. Waddington LAT** used Facebook to regularly post helpful information not only about local events and resources but helpful mental health articles and links from across North America. **Cariboo LAT** and **Pemberton LAT** created apps for cellphones and websites with handy local numbers and contact information.

35 RESOURCE DIRECTORIES:
These include hard-copy inventories, resource lists and other tabulations of all the organizations, community agencies, SU treatment programs, individuals and support services available in a community. 15 LATs took the most important numbers and put them on handy wallet cards, post cards, rack cards. Three LATs, **Comox Valley, Surrey North Delta,** and **White Rock South Surrey** created special prescriptions pads with local resource information that doctors could tear off and hand to young patients and families in their offices.

28 ASIST AND/OR SAFETALK TRAINING WORKSHOPS:
A special, award-winning program that was created in Canada, the Applied Suicide Intervention Skills Training program is the global standard in suicide intervention training; 15 LATs sponsored ASIST workshops for their members, with more than 200 trained. A further 13 LATs sponsored the half-day, related SafeTALK training, about how to talk to individuals who are suicidal and direct them to the right help.
See story page 46.

7 MENTAL HEALTH FIRST AID TRAINING WORKSHOPS:
Developed by the Mental Health Commission of Canada, the MHFA program, like a physical first aid program, is designed to teach people how to recognize the signs and symptoms of mental health problems; provide initial help; and guide the person towards appropriate professional services. LATs sponsoring this training include **Kitimat, Valemount, Revelstoke, Shuswap, Pemberton, Port Alberni** and **Sooke/West Shore.**

5 GP ATTACHMENT:
In the Interior and North, five LATs led initiatives to link young patients with mental health or substance use issues to a coordinated roster of family doctors willing to take on their care. See story next page.

10 SPECIAL CLINICS:
Creating new ways to connect with and provide services to youth with mental health and substance use challenges was fostered or accelerated by local LATs. See the stories on pages 32 to 36 about school clinics. **Kimberley/Cranbrook LAT** created a new Eating Disorder Clinic and a new way to approach youth with complex needs.
See page 38.

11 SUPPORT GROUPS:
Whether it is students mentoring students, or parents supporting other parents, 11 LATs across the province supported youth and families to create skills and networks to support each other. **White Rock South Surrey LAT**, for example, sponsored a peer mentorship program in which Grade 11 students mentored Grade 7 students at a local elementary school. **Bella Coola LAT** offered a peer-to-peer counselling course to local youth with school credits earned for participation. **North Okanagan LAT** co-created a support group for LGBT2SQ+ youth. **Sooke/West Shore LAT** created a parent support group that so far has hosted 15 information sessions on everything from ADHD, eating disorders, self-harm, sleep, fentanyl, trauma, and autism; 153 parents have attended. Four sessions were led by the parents, the others led by experts in the field. At every event, parent experience, and support of other parents, was front and centre. The program won a 2017 Victoria Community Leadership Award.

12 TRAUMA INFORMED PRACTICES:
Adverse childhood events, such as neglect, abuse, or trauma are known to greatly increase the risk of future mental health and substance use problems, 12 LATs around the province chose to sponsor various forms of trauma-informed workshops and initiatives to increase the knowledge and skills of care providers who respond to children, youth and families impacted by trauma. See feature starting on page 40.

GP AND SPECIALIST TRAINING:
Under the Collaborative, impetus was placed on greater training and support for family doctors and specialists who treat children and youth with mental health and substance use issues. See pages 51 and 52 for stories about the Practice Support Program's Child and Youth Mental Health Module and Learning Links, a new online training resource for pediatricians, general psychiatrists, ER physicians, GPs, nurses and clinicians.

LINKING TEENS TO DOCTORS

INTERIOR GPs AND SCHOOL COUNSELLORS COOPERATE TO ATTACH YOUTH TO FAMILY DOCTORS

THE FAMILY DOCTOR is the backbone of the Canadian health care system and often the first health professional a parent or guardian sees when a mental health or substance use issue arises for their child.

In many BC regions, however, some families are without a family doctor — they're called "orphaned" patients. This makes getting timely and effective care difficult.

"When patients don't have a family doctor they either go without care or go to a walk-in clinic or ER," noted Dr. Kyle Stevens, a family doctor in Summerland who is on the **South Okanagan Similkameen (SOS) LAT.** "ERs and walk-in clinics do not provide continuity of care and are therefore not good for mental health care — patients need the ongoing relationship with a family doctor."

Spurred by the connections and skills developed through the PSP Child and Youth Mental Health training module, and supported by four local LAT and the local Division of Family Practice "A GP for Me" initiative, family doctors in the Interior have stepped up to provide care to orphaned youth. It is a great example of the Collective Impact's focus on mutually reinforcing activities to bring about change.

Stevens, as well as more than 30 other Interior GPs, have signed up to accept orphaned youth patients who are referred from a school counsellor. This is called "attaching" a patient to a family practice.

So far in Summerland, eight GPs have signed up to attach patients and in Penticton, 11 GPs signed up. At least 17 school counsellors in the region are now involved in the referrals.

"They will have a youth sitting in their school office, who is in crisis or needs some form of medical care and, if the youth doesn't have a family doctor, they just pick up the phone," said Stevens.

In the South Okanagan, depending on where the youth lives, the call goes to a single office "hub" in Summerland (Stevens' clinic) or in Penticton. Those doctors' offices keep a roster of all the GPs who are part of the program; the office assigns the youth to the next doctor in the rotation and provides contact information to the school counsellor and youth. By the end of 2016, 24 young patients had been attached to doctors in those two communities by this simple but effective process. Stevens noted that having the school counsellor as the gatekeeper for referrals prevents GPs from being overwhelmed with new patients and therefore more likely to take part. As well, in Penticton, the Penticton District Community Resources Society, a local services agency, has provided family doctors with direct access to one of its family counsellors who is an expert at navigating the local system of care. This way, the doctor and youth feel well-supported to link with appropriate community services.

Dr. Kyle Stevens is one of more than 30 Okanagan GPs who have signed up to take youth with mental health concerns. Photo: Mike Steele

"This means we can tell family doctors who sign up, 'You are not left on your own. This comes with extra resources that might be helpful to you,'" said Stevens, who noted the new relationships with all the region's school counsellors have been supportive of collaborative care. "We now all know each other; we know who is on the other end of the line. And that is really helpful in making it easier to cooperate and provide wraparound care for the youth."

Summerland high school counsellor Brad Wise can now simply pick up the phone to connect a student without a GP to a nearby family doctor. Photo: Mike Steele

The Central Okanagan LAT, Shuswap LAT, and **Oliver/Osoyoos/Okanagan Falls LAT** also have their own initiatives to attach local GPs to orphaned patients. In the North, **Quesnel LAT** is also developing a plan to link GPs to teens.

In Kelowna, at least 10 doctors signed up and the list of participating doctors was distributed to all members of the Central Okanagan LAT. Dr. Marianne Morgan of Kelowna estimates her office has taken on 30 unattached youth under the initiative.

The Oliver/Osoyoos/Okanagan Falls LAT's "No Child Without a Doctor" campaign recognizes that most mild to moderate mental health concerns can be handled by the family doctor.

Stevens noted the role of the PSP-CYMH module was a key to the success of the initiative, as many of the family doctors who have taken the training are comfortable taking on young patients with mental health concerns. When he presented the model at a national mental health conference, "I had doctors come up to me after the presentation asking how they might do this in their own communities. It can feel overwhelming to them, but with a bit of structure it can be doable for the GP. "

ALL ON THE SAME PAGE: KNOWING WHAT TO DO IN A MENTAL HEALTH CRISIS

ACCESS to the right services in mental health crisis is essential. **Thompson LAT** members created a clearly defined Crisis Response Protocol that pre-dates the Collaborative but was enhanced by its cooperative structure. The eight-page document lists every entity in the region that might interact with a child or youth in mental health crisis — hospital, MCFD, GPs, schools, the RCMP, First Nations, etc. — and sets out expectations and agreements for how each will respond, including whom they call and connect with. As well, simple "What to Do" sheets were created. For example, GPs received a one-page document "Crisis Response at the Family Physician Office" that clearly details whom to call and when.

CRISIS RESPONSE at Family Physician Office
(up to 18 years old)

1 Call for an Urgent Assessment:

- Call Child and Youth Mental Health: **Weekdays, 9:00 am – 12:00 pm, 1:00 pm – 4:00 pm**
  North shore: 250-554-5800 — 905 Southill Street, Kamloops
  South shore: 250-371-3648 — 1165 Battle Street, Kamloops
- To access initial assessment youth/family will visit CYMH (North Shore, or South Shore locations, depending on individual's residence). Following an initial assessment by the Clinician, the Clinician will determine whether referral to hospital is required. If they feel a referral to hospital is required, they will contact Parkview Child and Adolescent Mental Health or KMHART to discuss the case.
- If referral to hospital is required, the CYMH clinician, in consultation with parent/guardian, will make a decision regarding the transportation of the client to the hospital (i.e, parent/guardian or RCMP).

2 Call for an Urgent Psychiatrist Assessment:

- Call **Parkview: 250-314-5629 — Weekdays: 8:00 am – 6:00 pm** to connect with child psychiatrist.
  Note: *Admission to Parkview for Crisis Stablization: Important for FP to be aware that the youth's care will be managed through Parkview until the crisis is over and they are transitioned to community resources for long term support.*

3 Send Patient to the Emergency Department/Parkview on Their Own:

- Physician to call Parkview to decide if patient should go directly to Emergency Department or sent directly to Parkview.
  Call **Parkview: 250-314-5629 — Weekdays: 8:00 am – 6:00 pm** to connect with child psychiatrist.
- Physician will prepare/collate information for family. Will send information electronically to the Emergency Department/Parkview. Ensuring that a warm handover occurs, where there is a conversation between the FP and Emergency Department Doctor/Parkview manager.
- Arrange transportation for patient and their family to the hospital in consultation with parent/guardian, will make a decision regarding the transportation of the client to the hospital (i.e, parent/guardian or RCMP).

4 Call for Escort to Hospital Via RCMP:

- For non-emergency call: **250-828-3000**
- For emergency call **911**

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DESIGNATED ER NURSE STREAMLINES CARE

Access to crisis response services in rural or remote communities can be particularly challenging. On the **Sunshine Coast**, aided in part by gap analysis and new relationships at the LAT, the Vancouver Coastal Health Authority combined vacant part-time positions to create the new full-time role of Mental Health Emergency Services Nurse. Kelsey Wagner, a trained psychiatric nurse, was hired for the position.

Now she works 8:30 am to 4:30 pm Monday to Friday out of the busy Sechelt General Hospital, taking calls from local GPs, families, the RCMP, and schools about anyone in mental health crisis. She then meets the individual either in the community or in the ER. Working with the local psychiatrist and addictions counsellor, she brings about faster assessment, treatment, and resolution of crises.

"The work of the Collaborative had identified that we needed some sort of streamlining on how children and youth come into the ER and the connections back to MCFD, the schools, and family," notes Susann Richter, Manager, Sunshine Coast Mental Health and Addictions, Vancouver Coastal Health who created the position for which Wagner "was a natural fit."

Richter noted the new position is getting lots of positive feedback from the ER, the police, the schools and from other stakeholders. "The Collaborative has been such an important entity in our community. It has led to a lot of positives — like having the mental health emergency services nurse working with it."

Kelsey Wagner at the Sechelt General ER
Photo: VCH Communications

To also help support children and youth who come to the ER, **Boundary LAT** conducted a four-month-long pilot. Using existing resources, a navigator role was created to provide more integrated care for children and youth with complex conditions or frequent visits to the ER. The LAT and community agencies are now exploring whether the role can be extended long term.

TAKING NOON-TIME CALLS

CARIBOO CHILD PSYCHIATRIST SUPPORTS LOCAL GPs TO IMPROVE REACH OF CARE

Dr. Matt Burkey. Photo: Monica Lamb-Yorski, Williams Lake Tribune

AT NOON EVERY DAY, Dr. Matthew Burkey blocks off an hour to take calls from family doctors in Williams Lake to discuss their young patients with mental health concerns.

As the new child and adolescent psychiatrist at the Cariboo-Chilcotin Child Development Centre — the first working full time in the region — Dr. Burkey feels one of the best ways to improve access to good mental health care for children and youth is to support local family doctors in providing effective care.

"With a population of about 55,000 over a huge area, it is impossible for one child and adolescent psychiatrist like me to meet all the needs," said Dr. Burkey, who arrived in Williams Lake from Baltimore in February 2016. But by making himself available every day for quick case consultations with GPs, "together we can do a form of triage, avoid escalations to a crisis, and I can help them provide good care while the youth may be waiting for other services."

That outreach has marked Dr. Burkey's style in his first year and it's a model for the province of how to distribute the expertise of child and adolescent psychiatrists. Dr. Burkey also meets weekly with the Ministry of Children and Family Development Child and Youth Mental Health team to discuss cases. He also sees individual patients.

Dr. Burkey, who grew up in Nebraska, completed his psychiatry training at the Johns Hopkins School of Medicine and conducted research as a faculty member in its Department of Psychiatry. Dr. Burkey is also a public health researcher with an interest in improving access to mental health services in underserved communities globally.

While his wife hails from Williams Lake and the main reason for the move to BC was to be closer to her family, Dr. Burkey noted that the CYMHSU Collaborative's **Cariboo LAT** helped cinch his decision to relocate.

"The things they are doing are cutting edge — there are more than 18 members, from the RCMP, schools, medical community, and organizations, all seeing how they can collaborate."

Dr. Burkey noted the LAT has greatly helped him in his new practice "from organizing meetings with the six family practice offices in town, to helping survey GPs on their continuing education needs, to arranging meetings with Aboriginal practitioners and organizations."

Now, Dr. Burkey said, "we will be moving forward with the LAT on the identified priorities of improving crisis response services and supporting primary care providers on the frontlines."

C&A PSYCHIATRY TRAINING SPOTS INCREASE WITH ADVOCACY FROM COLLABORATIVE

Doctors who train in a region tend to stay and practice there. That's why the news, in the fall of 2016, that UBC's Faculty of Medicine would increase the sub-specialty training spots for Child & Adolescent psychiatrists from three to four in 2017/18 was celebrated. "This is fantastic news and could not have occurred without the Collaborative's efforts, particularly the strong advocacy of the Physician Recruitment and Retention Working Group," noted Dr. Jana Davidson, Psychiatrist-in-Chief, BCCH, and Head of Division of Child & Adolescent Psychiatry, UBC. Davidson is also the co-chair of the Mental Health Faculty of the CYMHSU Collaborative.

RAPID ACCESS PSYCHIATRY CLINIC

The **White Rock/South Surrey LAT,** along with the Vine Youth Clinic, identified the need for more psychiatry supports in their community, especially for children and youth with low-to-moderate levels of mental health conditions, and for GPs to access a quick psychiatric consult. In response, the White Rock/South Surrey Rapid Access Clinic was formed as part of the Vine Youth Clinic. The RAC is a partnership among MCFD, Fraser Health, and the local White Rock/South Surrey Division of Family Practice. A child and adolescent psychiatrist devotes a full day every two weeks to complete assessments for children and youth referred by local physicians. Follow-up is limited to one to two sessions, allowing for increased capacity and timely response. As of Fall 2016, referrals were being completed within two weeks. The referring GP still manages the child or youth for ongoing support, incorporating the recommendations made by the psychiatrist.

RIDGE MEADOWS YOUTH WELLNESS CENTRE

The **Ridge Meadows LAT,** in consultation with its youth and parent advisory committee, decided that a youth centre was needed to provide a continuum of services to youth up to the age of 25. In addition to providing an advocate to assist youth and their families to access mental health and substance use services, the centre also provides psychiatry supports. With no current child and adolescent psychiatrist in Maple Ridge and Pitt Meadows and ongoing challenges to recruitment, the LAT helped coordinate a three-month pilot project where the local Division of Family Practice paid Vancouver child and adolescent psychiatrist Dr. Matt Chow his sessional rate for the travel time it took him to come from Vancouver to their community. The pilot was successful and since May 2016, Dr. Chow has assessed or followed up with 87 youth, 52 of whom have been referred on to MHSU programs and services.

VIDEO PSYCHIATRIC CONSULTATION PILOT IN EAST KOOTENAY ERs

Using videoconferencing, physicians in the Creston Valley Hospital and Golden Hospital Emergency Departments will have access to psychiatrists at the East Kootenay Regional Hospital in Cranbrook for consultations and patient assessments. The project, which involves the **Creston** and **Golden LATs**, was initiated by Cindy Golbeck, an acute-care manager for Interior Health, as part of her Master's thesis in psychiatric nursing. Videoconferencing will be used to prevent unnecessary admissions, support local treatment of MHSU patients in the ER, and build primary care MHSU capacity in the Creston and Golden communities. It will also provide sustainable, collaborative assessment, and consultative services by specialists to GPs, patients, and families in the moment of crisis in the ER. The pilot also seeks to reduce the need for transportation out of the smaller communities to the larger hospital. If transportation is necessary, however, it will build continuity of care between the hospitals.

LATs SUPPORT LGBT2SQ+ YOUTH

The adolescent years are tough for all youth, but for those who are experiencing concerns around their sexual identity or their gender, the challenges can be even greater.

In fact, research shows that LGBT2SQ+ (lesbian, gay, bisexual, transgendered, two spirit, queer spectrum) youth experience higher rates of depression, anxiety, obsessive-compulsive and phobic disorders, self-harm, substance use and suicidality. They are also more apt to be bullied or ostracized. If they turn to the internet for information or help, they can get misinformation or be targeted by online predators.

"We need to acknowledge there are no services, no representation, nothing to support these vulnerable kids," says Deon Soukeroff, Child, Youth and Family Counsellor at Vernon's Family Resource Centre Society for the North Okanagan.

During the Collaborative, LATs have reached out to support LGBT2SQ+ youth in their regions.

For example, the **North Okanagan LAT** in Vernon helped establish a weekly support group called Life Gets Better Together (LGBT). The group is for 14 to19-year-olds, but no one is turned away. The meetings, which feature discussions and sometimes guest speakers, are facilitated by professionals like counsellors, social workers, public health and street nurses, who volunteer their time. Twenty youth have attended the program since it started in October 2016, with a core group of seven or eight youth.

The **North Okanagan LAT** is also providing funds for Vancouver trainers who specialize in LGBT2SQ+ issues to train volunteers and others in the community as a way to further build a knowledgeable network of people who can support these youth in the region.

Revelstoke LAT has helped make their community a more inclusive place for all youth. In 2016 hundreds of Revelstoke students assembled to learn about the LGBT2SQ+ spectrum from Vancouver based organizations Out in Schools and Call Out. Two workshops were also held for community members and service providers with support from the LAT. The LAT has also played a role in supporting Community Cafes for LGBT2SQ+ youth and events organized by Safe Spaces Revelstoke, including their participation in the Canada Day parade.

WHO WANTS TO KNOW MORE ABOUT MENTAL HEALTH CLINICS IN SCHOOLS?

BC children and teens spend an average of seven hours each weekday at school between September and June. That is more time spent in a single place than in any other spot except sleeping in their beds.

School personnel worry about increasing levels of stress and anxiety they see in the classroom and are looking to mental health experts to help them help students while they are at school.

Creating a wraparound health centre in a high school can topple a big barrier for youth who need timely care for mental, physical and social health concerns but can't get to a clinic in the community.

Over the past two years, five school-based clinics have been established in BC with the help of the Collaborative. They are prime examples of Collective Impact activities, as they take multiple local partners and funders, cooperating with a shared agenda and mutually reinforcing activities, to bring them to fruition.

NANAIMO'S JOHN BARSBY WRAPS STUDENTS IN TOTAL CARE

AN UNUSED CLASSROOM at John Barsby Secondary School in central Nanaimo has been transformed into a space that offers students total health care, 12 months a year, four days a week.

Barsby Clinic Staff, L to R: Dr. Randal Mason; Maria Devesa, Public Health Nurse; Erin Kenning, Public Health and Centre Coordinator; Angela Meredith, Public Health Nurse; Carol Hadley, Public Health Nurse; Belinda Walle, Admin Assistant.

The new John Barsby Wellness Centre, on the first floor and right beside the school counsellors' office, provides wraparound physical, sexual, and mental health care to more than 700 inner-city students.

"We know that young people often don't seek out health care providers when they have physical and mental health concerns; they may fear stigma or not want their parents to know. They may not even have a doctor," explained Dr. Wilma Arruda, a Nanaimo pediatrician and local champion of the new clinic.

Called JBWC for short, the clinic has two examining rooms, a nursing and reception station, a small washroom, and a central common area with comfortable couches, puzzles, and magazines. A basket of fresh apples is always on the reception counter.

In just over a year, from September 2015 to December 2016, students made 1,339 visits for everything from scratchy throats and sore knees to contraception and mental health concerns, like anxiety and depression. (See results in box on this page.)

The Collaborative has not only assisted but sped up the clinic's creation, many note, as it helped bring partners to the table through the LAT and fostered the relationships and agreements needed to move the clinic forward.

"The partners had to learn about each other's systems and what to expect in terms of other organizations' approval processes. It takes time to build trust," said Bob Esliger, Assistant Superintendent of Nanaimo-Ladysmith School District 68.

The JBWC, which was being planned before the start of the Collaborative, was the first of the school-based clinics to open. It brought 19 disparate partners together through the **Nanaimo LAT**. The Nanaimo Division of Family Practice applied to the GP Services Committee "A GP For Me" initiative (a joint initiative of Doctors of BC and the Ministry of Health) and received $200,000 to renovate the large classroom into a suite of rooms for the clinic.

The clinic offers a range of staff: a fulltime public health nurse; a GP two mornings a week; a part-time social worker (with plans to increase this to full-time); an Aboriginal Services CYMH-MCFD worker a half day per week; a Discovery Youth and Family Substance Use Services counsellor a half day per week; an administrative assistant two half days per week; and practicum nursing students who also teach health promotion in the classrooms. The school counsellors are next door and work with the clinic to extend services to the students.

In the fall of 2016, the JBWC doctor and nurse began providing services at Nanaimo District Secondary School every Thursday, closing the JBWC for that day — and hopefully fostering the start-up of a new school-based clinic there.

JBWC VISITS SEPT. 2015 - DEC. 2016

1,339 Student Visits

- **500** Females Age 13-15
- **80** Males Age 13-15
- **600** Females 16-18
- **102** Males 16-18
- **54** Unknown Age
- **84%** Saw a Nurse
- **23%** Saw a GP
- **3%** Saw a MH Counsellor

Reason for coming:

- **39%** For Physical Problem
- **31%** For Sexual Health
- **11%** For Mental Health
- **18%** Other

A TRIO OF SAFE, WELCOMING CLINICS OPEN IN SOUTHERN VANCOUVER ISLAND SCHOOLS

IN 2016, THREE SCHOOL-BASED CLINICS OPENED with help from the coordinating activities of the **Sooke/ West Shore LAT** on Vancouver Island, which brought multiple agencies and individuals to the table to hammer out agreements.

"The three clinics are a huge collaborative effort that takes key partners and hundreds of hours to get off the ground," said Dr. Ellen Anderson, a family physician who co-chairs the Sooke/West Shore LAT. Key partners included Island Health's Dr. Richard Crow, School District 62's Superintendent Jim Cambridge, the principals and staff of the three high schools, the region's public health staff, and, noted Anderson, the youth themselves.

"The clinics are definitely worth it, but they are not simple and straightforward things to do," Anderson said.

BELMONT SECONDARY WELLNESS CENTRE

Located in the fast-growing community of Langford, a municipality of Greater Victoria, the new clinic in Belmont Secondary opened in September 2016, a year after the new 1,200 student school was built in a new location. Dr. Anderson learned that a nurse-managed Wellness Centre was in the early stages of planning there.

In partnership with SD62 and Island Health, Anderson and the LAT worked toward adding physician services and took the lead in recruitment, securing equipment, and developing policies and procedures. The LAT also included the students – the people who want and need support – to help plan what the clinic would look like and what services it would offer. A Youth Health Committee (YHC) run by students, attended by the public health nurses and supported by LAT staff, generated ideas and set priorities, creating a Facebook thread for ongoing communication.

"The space is really comfortable, almost serene," said Christine Camaso, a Grade 10 Belmont student. "Kids sometimes just hang out there because it feels safe and welcoming."

Ashley Birtwistle, EMCS clinic admin assistant. Photos: Rick Robinson

ROYAL BAY SECONDARY SCHOOL CLINIC:

Also located in Langford in a new 800-student high school, the Royal Bay Clinic was established by Island Sexual Health Society and opened in September 2016. The LAT strongly advocated for a family physician to join the team so youth could access health and mental health services at the Clinic. With support from Island Health, the LAT is recruiting another doctor to join the team in 2017. A youth health committee meets twice a month with the LAT engagement coordinator at Royal Bay Secondary to discuss clinic services and ways to promote use of the clinic by students, especially young men. Working with Island Sexual Health, the YHC created a youth sexual health ambassador role. If approval is obtained from the schools, the youth ambassador will provide outreach and peer counselling services. More student engagement and health promotion events are being planned, including an ambitious mental health day in 2017. The Royal Bay YHC also recently received a $500 grant from the RCMP to create a marketing strategy to destigmatize the use of sexual health services by young male students.

EDWARD MILNE COMMUNITY SCHOOL CLINIC

Located in Sooke and with a catchment area that includes First Nations and rural/remote communities, the LAT worked with the principal of the 700-student Edward Milne Community School to develop a clinic that offers family physician services one half-day a week, with three local physicians sharing the role. Island Health provides a Medical Office Assistant on clinic days. Plans are for the Sooke Family Resource Society and Island Health's Discovery Program each to have a part-time staff person on site. In the two months after opening in September 2016, 57 students visited the centre and 12 youth joined the school's Youth Health Committee, which is also attended by the public health nurses.

A SCHOOL CLINIC ON HAIDA GWAII TREATS AN UNDERSERVED COMMUNITY

Children, youth, and families on Haida Gwaii are more likely to develop health problems, including chronic conditions like depression, than most other British Columbians, researchers have found.

Moreover, mental health services are thin; only one school counsellor and one CYMH-MCFD worker serve the entire archipelago.

A child and adolescent psychiatrist visits only a couple of times a year. Transportation is limited, with many Haida Gwaii youth leaving their community only when they are bused to school each day.

The **Haida Gwaii South LAT** raised the idea of establishing a high-school-based clinic in a brainstorming session. Two GPs, Dr. Tamara Pacholuk and Dr. Gordon Horner, stepped forward to pursue the idea with the school principal, Deavlan Bradley, who eagerly agreed to make space.

Since April of 2016 the doctors have spent two days a month in the 145-student GidGalang Kuuyas Naay Secondary School (formerly called Queen Charlotte Secondary School).

"Being on salary with discretionary time helped make it possible," said Dr. Pacholuk, one of six family physicians on the south island.

The clinic, offered from 10 am to 12:30 pm, responds to youth who might not otherwise be able to access health services or who do not want their parents to know they are seeing a doctor. Students can book appointments or walk in during the lunch hour.

Bradley said students quickly accepted the clinic and a steady stream of students use it. "They are perfectly comfortable coming to the office at lunchtime and saying, 'hey is the doctor in?'"

If the clinic weren't there, Bradley noted, the students might go to the emergency room, try to walk in to the community clinic, or simply go untreated.

One youth, who told the doctors that his parents don't believe that mental health problems exist, was able to get help on his own from the school doctors and now is receiving regular counselling.

"The clinic really meets the Collaborative's goals of helping youth better access services," said Dr. Pacholuk.

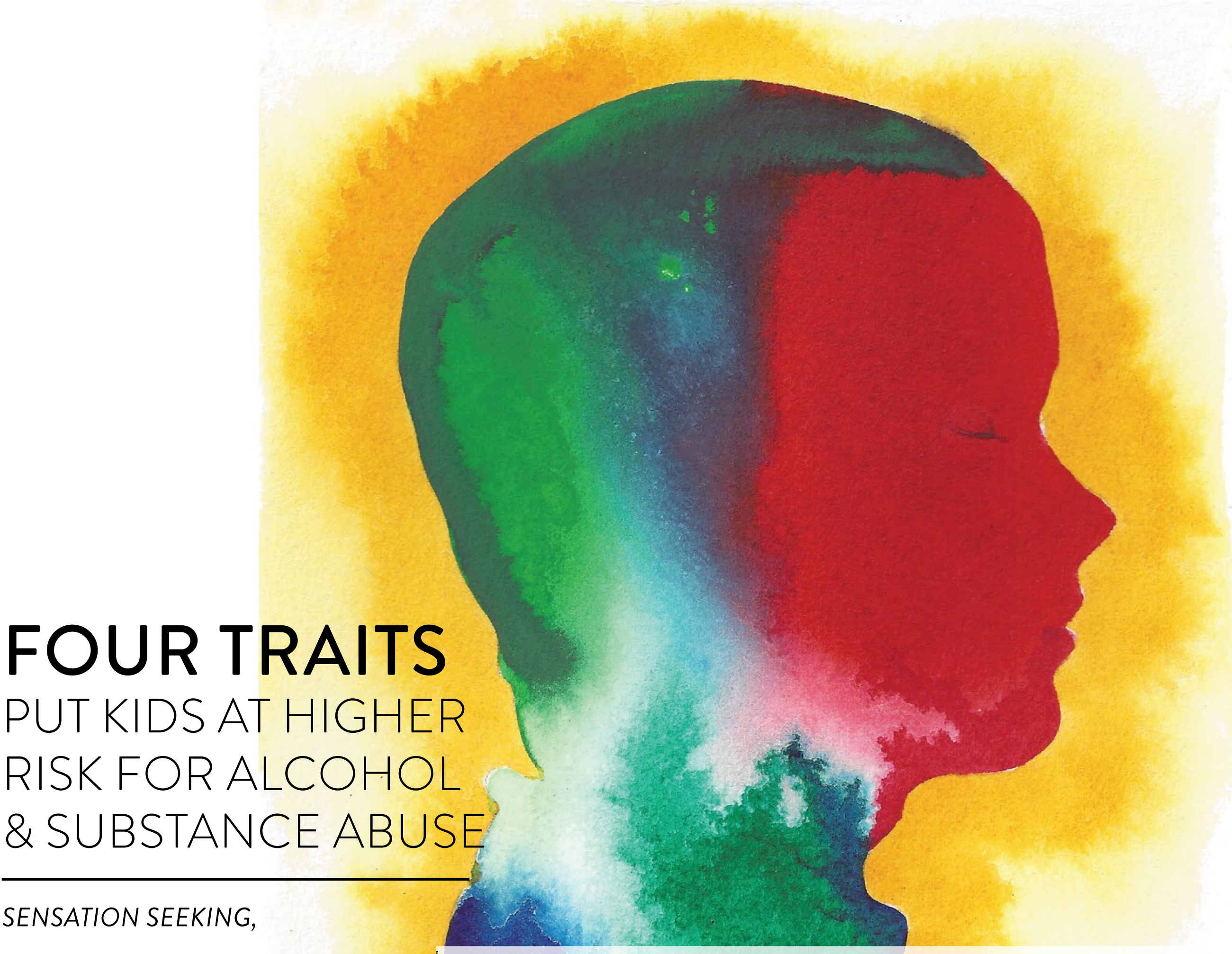
YOUTH CLINICS

IT IS NOT JUST "BUILD IT AND THEY WILL COME"

LATs in the Fraser, Interior and Island regions moved to fill service gaps by creating youth wellness centres in their communities. In December 2016, **Ridge Meadows LAT** Youth Wellness Centre opened for drop-ins on Thursdays from 4-6 pm at the Greg Moore Youth Centre. There youth can see one of four rotating GPs or the Youth Advocate to get health and mental health care or resource information. The drop-in is offered separately from the services provided by C&A Psychiatrist Dr. Matt Chow (see page 31). The **North Okanagan LAT** established the Vernon Youth Hub, located at the Teen Junction Youth Centre. On Wednesdays from 2-4:30 pm, the hub links teens to counsellors from community agencies and Interior Health. Both the Youth Wellness Centre and the Youth Hub are establishing connections with local schools and engaging in outreach to encourage youth to visit the centres. Both LAT leads note that it is expected that this process will take time.

One of the first to establish a clinic for youth under the Collaborative, **Cowichan LAT** in October 2015 opened its Youth4 Wellness centre in a portable classroom beside the Cowichan Valley Open Learning Cooperative School. For a number of reasons, youth chose not to come to the portable, where the Adult Education Centre was also located. After many efforts to encourage youth visits, the Centre closed in April 2016. Cowichan LAT is now working with 20 to 30 vulnerable youth, aged 12 to early 20s. "We are letting youth lead it, and finding back door ways to give them access to services and connect with them", says Meghan Marr, LAT project lead.

During the Collaborative, the BC Integrated Youth Services Initiative (BC-IYSI, now known as BC FOUNDRY) created five new youth hubs, one in each health region. Some LATs were very involved in the proposal process. The **Central Okanagan LAT** is listed as a key partner in the Kelowna FOUNDRY. Some communities, such as Langley, while not selected by BC FOUNDRY, decided to create their own youth clinics with local partners.



FOUR TRAITS
PUT KIDS AT HIGHER RISK FOR ALCOHOL & SUBSTANCE ABUSE

SENSATION SEEKING, IMPULSIVITY, HOPELESSNESS, AND ANXIETY/SENSITIVITY

NEW INTERVENTION AIMS TO CUT THE RISK

Illustration by Betty-Ann Lampman

MOST TEENAGERS who try alcohol and drugs do not become addicted; so what's different about the ones who do?

Researchers have found that four tendencies raise the risk of substance misuse: sensation seeking, impulsivity, hopelessness, and anxiety/sensitivity. These can be seen as the downsides of otherwise positive traits; sensitive kids feel empathy for others, for example, and impulsivity can mean a teen is action-oriented and a go-getter.

Dr. David Smith, an adolescent and adult psychiatrist and the medical director of the Okanagan Psychiatric services for Interior Health, worries about how the negative aspects of these traits can lead to addiction. "Kids who are anxious or hopeless may try to medicate the distress away, while those who are impulsive or sensation-seeking may simply say 'yes' without giving it much thought," said Smith, who is on the **North Okanagan LAT,** located in Vernon.

Smith has been following the promising work of a University of Montreal team led by Dr. Pat Conrod, who created a simple way at school to test and identify those kids who have higher levels of the four traits. The kids who might go on to abuse drugs or alcohol receive training with cognitive behavioural techniques to address problematic thoughts, emotions, and behaviours to try to cut the risks.

This training, called Preventure, is coming to Vernon with planning, funding, and logistical support from the North Okanagan LAT. It will roll out in 2017 for all Grade 8 students in five high schools.

TRAITS AS STRENGTHS

Preventure has been tested with very good results in other parts of Canada, the UK, Australia, and the Netherlands, where studies found the intervention reduces the risk of drinking and drug experimentation for the youths who got the training. It even lowered the rate of alcohol and drug use among all the students in the grade. The researchers say that is because some of the "cool" kids learned the skills, thereby reducing the peer pressure among their classmates to experiment. The training also recognizes that the four traits have positive effects, making it a program based on strengths, not perceived weaknesses.

Doug Rogers, the Vernon School District's Substance Use Prevention Counsellor and a LAT member, is excited about the program's potential. "Every year I see at least 300 kids from the high schools in our region who have already developed a problem. Getting to the root causes early is essential if we are going to make a difference down the road."

This past fall, Jean-François Morin, the lead trainer for Preventure, came to Vernon to train eight school counsellors in the personality testing and the CBT techniques. Dave MacKenzie, School Counsellor at Vernon's Clarence Fulton Secondary School and current president of the BC School Counsellors Association, took the two-day training and was impressed. "The research is very solid and it feels incredibly doable as a counsellor. I feel sure it will make a difference," MacKenzie said.

GRADE 8s TO BE SCREENED

This winter, every Grade 8 student — about 750 youth — will take a screening test called the Substance Use Risk Profile Scale (SURPS). It is expected that about 300 of those tested will be found to have at least one of the four personality traits at levels outside the normal range.

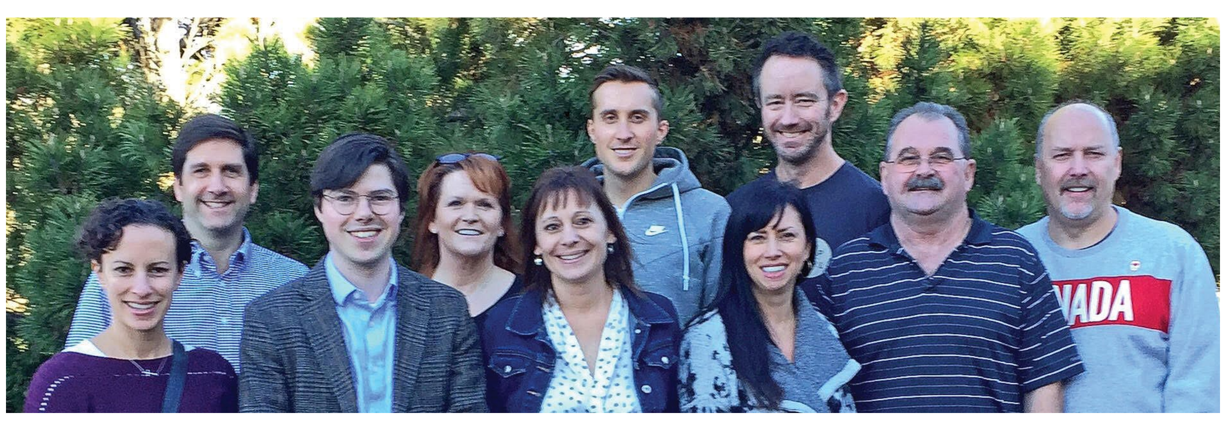
Then, without labelling or setting them apart, those students will be given an intervention tailored to the trait. Each of the four interventions consists of two, 90-minute CBT training sessions.

"It is framed in a very positive way," said Smith. "The anxious kids will be told, 'Isn't it great that you are so sensitive and so attuned to others,' and the kids with impulsivity will be told, 'Isn't it great that you are action-oriented and quick to engage.' And then they will be taught how to better cope with positive and negative aspects of this trait in a way that helps get them through school, and function better in life, in jobs, and in relationships."

RESULTS FOUND TO ENDURE

Results in other countries show the positive effect of the single intervention lasts for at least two years — protecting the youth during the first onset of experimentation. But another benefit is that the training of the school counsellors can help re-affirm the skills with the various youth anytime throughout their high school years. "That is one aspect that really excites me; we get to know these kids and better support their needs for the next four years," said MacKenzie.

Dr. Marvin Krank of the UBC Okanagan, will be following outcomes of the Vernon youth. Depending on the results, Preventure programs could be offered in other BC schools.



Preventure team at the training day, L-R: Hedi Routley; Dr. David Smith; Jean-Francois Morin, PhD; Sandie Glinsbockel; Karen Cleland; Geordie Reid; Brandice Mohr; Chris Colclough; Charlie Mcgarrity; Dave MacKenzie.

A NEW PROGRAM HELPS KEEP PARENTS & KIDS CONNECTED BEYOND GRADE 3

Parents pay close attention to what's going on in their children's classroom and at school when the kids are between kindergarten and Grade 3, according to Jewelles Smith, Project Lead of the **Revelstoke LAT**. Parental involvement drops when children grow older; but that is when the stress and anxiety of school can start to increase.

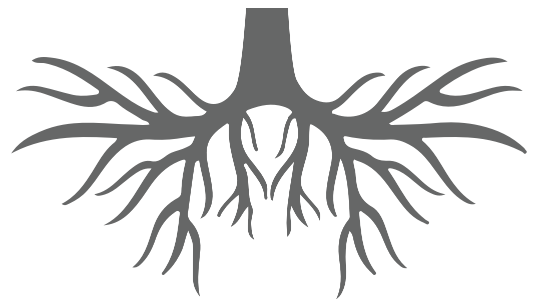
That is why the Revelstoke LAT developed Parents as Ultimate Supports and Educators (PAUSE) in 2016. The program aims to strengthen relationships among families, teachers, and communities so they can wrap around children and build resilience. It provides children, teachers, and families with tools to manage anxiety and stress and promote mental wellness.

Under PAUSE, teachers in Grades 4 and 5 work with a facilitator to prepare in-class sessions with children and additional sessions with both families and children. The joint sessions include a presentation to parents, group activities for parents and children, a take-home kit with handouts, books to read and games to play. Children and parents learn to recognize and respond to anxiety, stress, and depression through relaxation techniques, mindfulness, and conversations. Resource lists and mental health apps are also reviewed.

The Revelstoke LAT received funding support from the Columbia Basin Trust to pilot the program in one elementary school in 2017. If the pilot is successful, LAT partners hope to offer PAUSE in other Revelstoke elementary schools and expand it to other school districts.

GRASS ROOTS POWER

HOW ONE LAT'S INCREMENTAL CHANGES CREATE BIG RESULTS



WHEN THE COLLABORATIVE STARTED, the region of Kimberley Cranbrook was like many in BC — the physicians and the MCFD-CYMH clinicians worked in two completely separate systems, even though the combined population of the two towns was under 30,000 people.

"We didn't know each other. We didn't know how to talk to each other. We didn't contact each other about shared patients," notes Jennifer Westcott, MCFD Team Leader, who is one of the **Kimberley Cranbrook LAT** co-chairs. Westcott is the first to admit that when the Collaborative first started she was a reluctant participant. "I resisted the process. When we first met, I wanted to go running from the room," she laughs.

Now the Kimberley Cranbrook LAT is a stellar example of the power of the Collaborative model to build relationships and bring about lasting grassroots change to child and youth mental health services. Key team members are now coaching other LATs in BC to show how they did it.

"Everything we have done has arisen out of building relationships and trust, being honest and authentic with each other and letting our walls come down," says Dr. Cecile Andreas, a local family doctor and another LAT co-chair.

Initial struggle to build trust:

The first year it wasn't easy to establish shared perspectives, to agree on a common agenda and decide on a small test of change. LAT members described this early time as one of "confusion and tension." Team members describe the first significant shift was being comfortable sharing where they were struggling. One area was eating disorders, which affect six or seven youth, usually teenage girls, each year in the region. Doctors and mental health clinicians described feeling "very scared," and "ill-equipped" to meet the needs of these complex patients. "The kids are so scary because you know they can die at any moment," said Westcott. They had found an issue the majority could get behind: improving eating disorders care.

Eating Disorders Workshop: The LAT's first project was to invite six provincial experts from the specialized eating disorders clinic at BC Children's Hospital (BCCH) to their community for a day-long workshop in March 2015. It was attended by 90 people — GPs, specialists, mental health clinicians, community agencies, school counsellors, hospital dietitians, and psychologists. Terri and Rylee McKinlay, a mother and daughter who have been key participants in the Collaborative, spoke about Rylee's experience with anorexia, which included a nine-week inpatient stay at BCCH in 2012, and their need to move away from Kimberley to obtain more specialized care as part of her recovery. The workshop evaluations were uniformly positive, with the majority of attendees saying the event met or exceeded their expectations and got all the providers on the same page." Because of the workshop, ED care improved the very next day," said Westcott.

Eating Disorders Videos: The workshop was videotaped and subsequently edited into seven distinct learning modules, including the family journey, medical assessment and management, team roles, Family Based Therapy, meal support, and more. The videos were released

province-wide in Spring 2016, creating an accessible record of the workshop and spreading the knowledge and expertise of the BCCH experts across the province.

Walking across a parking lot to new ED Clinic: In Summer 2015 local providers joined forces to create a Child and Adolescent Eating Disorder Clinic in Cranbrook, held in the pediatricians' office every second Tuesday. The MCFD clinical counsellor walks across a parking lot from her office to join the doctors seeing young patients. The new clinic — which came at no increased cost — now provides consistent assessment, treatment and care management that aligns with the BCCH program. A dietitian is now a part of the treatment team. "The clinic has resulted in improved teamwork, further resulting in improved patient care," says a local pediatrician. As of Winter 2017, 21 youth were being seen by the clinic; youth were being seen earlier in their illness; and fewer youth were being referred to BCCH.

Parent Support Group: The region initiated a local parent support group in October 2015. Meeting from 10 am to 11:30 am on the alternate Tuesday from the ED Clinic and led by the MCFD clinical counsellor, the support group welcomes mothers and fathers, as well as other family members to share stories, successes, frustrations, emotional support, and logistical information, such as provincial travel, medical leave, and other subsidies. Family and youth say the parent support group and the shared appointments between the pediatricians and MCFD "make it feel like we are in Vancouver."

ED "step down" clinics: With the ED Clinic reaching capacity, the LAT is creating clinics in each of the six main communities (Creston, Golden, Invermere, Kimberley, Cranbrook, Fernie). Called Step Down clinics, in these sites a local MCFD clinician and family doctor with an interest in ED will be trained to provide support to patients who are now coping better. This will help create more capacity for the Cranbrook ED clinic to accept youth at higher risk. The training will occur in Winter 2017 with the step down clinics opening shortly after.

Complex Care Clinic: The success of the ED integrated model has led the region to apply a similar approach to youth with very complex mental health needs. Now the MCFD clinician, physicians and others involved in the care of several very complex patients see the patient together to discuss his or her needs and to provide more coordinated and supportive care.

Dr. Cecile Andreas and Jennifer Westcott. Photo by Les Bazso

Rylee and Terri McKinlay. Photo by Les Bazso

GP Residency Program with CYMH team: Each year, eight or nine University of BC medical students do their family practice residency in the region. In 2016, the Kimberley/Cranbrook LAT began introducing the residents to the MCFD-CYMH system, by having them spend time at CYMH, and providing them with an introduction to its approach and services to children and youth with mental health concerns. The intent of this exposure is to have these soon-to-be family doctors acquire a unique understanding of CYMH care through exposure to MCFD processes.

Ongoing education and engagement: The LAT is holding education sessions for doctors and other health providers on specificmental health topics, including the visiting child psychiatrist.

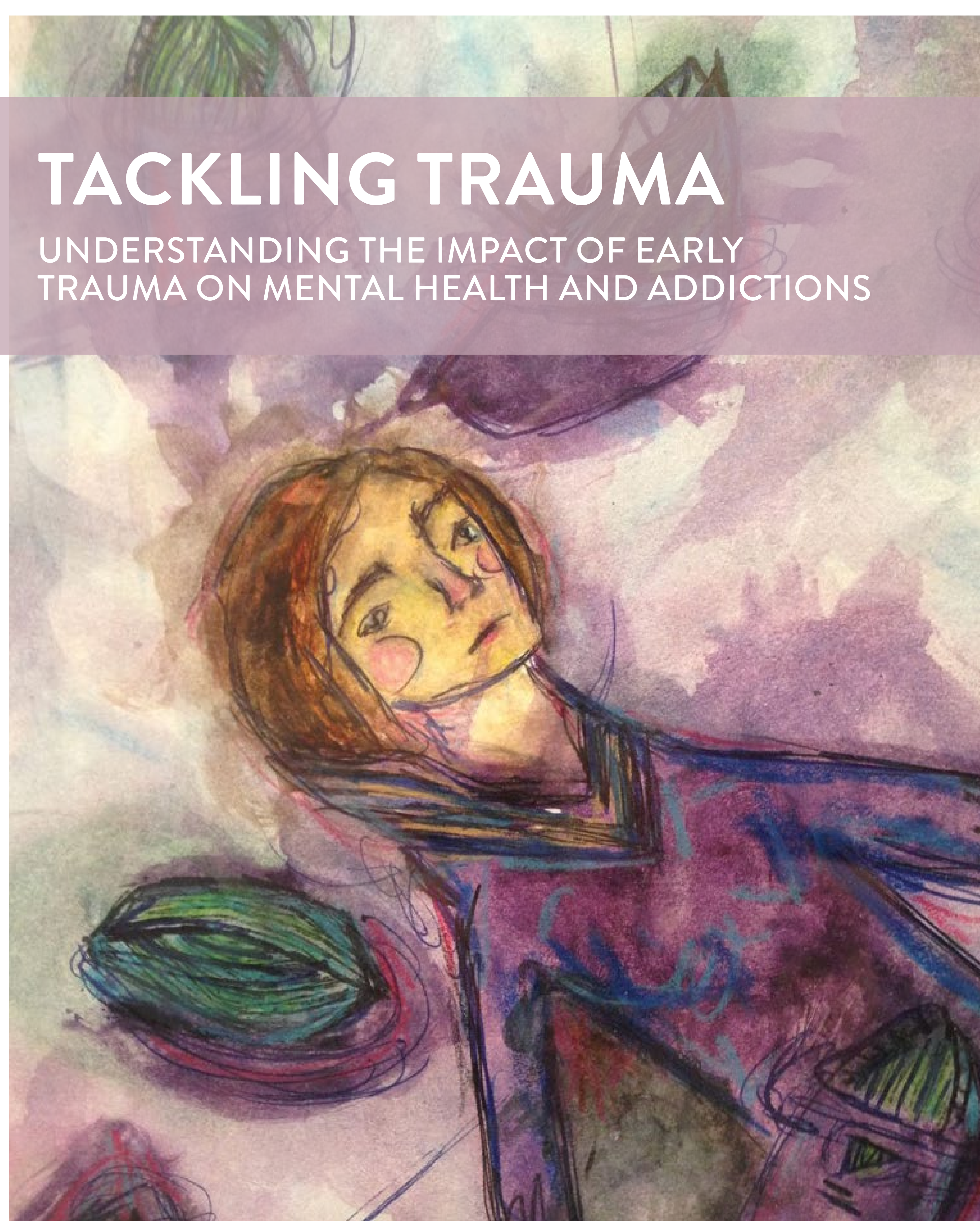
Improved communications, parent support groups and lunch meetings: Facilitated through the LAT, local GPs and MCFD-CYMH staff are working on shared communication models that enable them to talk regularly about shared clients to integrate their care. The LAT is also working on developing parent support groups that will be co-facilitated by GPs and MCFD-CYMH. Regular lunch meetings are being held between doctors, their office staff and the CYMH staff to discuss issues and plan solutions.

LAT members note that these step-by-step actions have transformed how people work together and also transformed their local system of care, creating more integrated and responsive mental health care for children, youth and families in the region. In fact, Westcott and Andreas, now regularly meet to walk in the local woods, putting their heads together to ask: "What can we do next to make things better?"

Say both:"This work has been the most rewarding in my entire career."

TACKLING TRAUMA

UNDERSTANDING THE IMPACT OF EARLY TRAUMA ON MENTAL HEALTH AND ADDICTIONS



"Drowning in Sorrow" Painting by Phoebe Bizzaro, Grade 10, Smithers Secondary School

IT HAS BEEN CALLED "THE GREATEST public health study" that — up until recently — "few knew."

In 1995, the US Center for Disease Control and Kaiser Permanente, a US health care organization, began the Adverse Childhood Experiences (ACEs) study. Over the course of the next few years the study surveyed more than 17,000 adults and in doing so confirmed the indisputable link between adverse events in childhood and future health problems, including much higher rates of mental health and substance use disorders.

The higher the number of ACEs, the study found, the higher the risk of future health, social, and behavioural problems. The link, the key researchers noted, is as strong as the link between tobacco and lung cancer.

Since that time numerous studies, in the US and the world, have confirmed and expanded on the impact of childhood trauma and neglect. Other researchers have investigated the neurobiological mechanisms that may underlie the link, such as the impact of stress hormones on the developing brain and the endocrine system. Still others have been studying what can be done to mitigate the effects.

The result is that, increasingly in the last few years, trauma-informed and trauma-sensitive approaches are being applied to children and youth with mental health and substance use issues.

During the Collaborative, **12 LATs** have undertaken initiatives and activities to increase the awareness and practice of trauma-informed care, or to create more trauma-sensitive environments in which children and youth can thrive.

Experts in the literature note that applying a trauma-informed lens to the care of individuals with mental health and substance use issues is important for a number of reasons. It helps provide more empathic and effective diagnosis and treatment; it identifies some of the underlying reasons why children and youth may be having emotional, behavioural or mental health problems or self-medicating; and it helps ensure that care providers or teachers do not re-traumatize them in the way they handle or treat their issues.

Langley Youth Advocate Corey Reid, co-chair of the **Langley LAT** and a youth rep on the Steering Committee, eloquently shared his story during his keynote speech at Learning Session 7. He told about his experiences and the dire cost of unrecognized trauma. He witnessed a horrendous suicide as a toddler, but no care provider diagnosed or understood his severe post traumatic stress disorder. Between the ages of 13 and 17 he saw untold numbers of mental health and addictions workers "who all focused on my addictions as the problem," he said. "I wish more people had known about trauma-informed care back then."

The following four pages highlight some of the unique ways LATs in the Collaborative have approached trauma-informed care and created trauma-sensitive environments.

RE-WIRING THE TRAUMATISED BRAIN

Two LATs in the Collaborative — **Mt. Waddington LAT** and **Boundary LAT** — have explored the trauma-healing work of Dr. Bruce Perry, who is the founder of the Texas-based ChildTrauma Academy (childtrauma.org). Dr Perry, who holds an MD in psychiatry and PhD in neuroscience, was the Medical Director of the Alberta Mental Health Board's Provincial Programs in Children's Mental Health from 2001 to 2003, and continues to have strong ties to Alberta and BC.

He specializes in the neurobiology of trauma, and has founded a method, called the Neurosequential Model of Therapeutics (NMT), which maps affected areas of the lower brain structures and uses developmentally appropriate repetitive movements and physical activities to re-wire the child's traumatised brain. (See Six Rs box.)

In 2016 Dr. Perry was sponsored by Mt. Waddington LAT to visit their community. He came to Port Hardy, met with doctors and mental health experts, toured the school, and connected with youth and educators. More than 200 people attended his public presentation. His visit inspired the LAT to further foster trauma-informed care and create a trauma-informed community. They are now using Perry's video materials and curriculum to train providers in his methods. During his visit to Canada he also went to the Comox region and presented to physicians and mental health care providers, a number of whom are on the **Comox Valley LAT** (his visit there, however, was sponsored by another organization.)

In November 2016 the **Boundary LAT** sponsored a free training session with Dr. Emily Wang from Calgary's Hull Services Society, who is a Fellow of the ChildTrauma Academy and has been trained by Dr. Perry in NMT methods. Wang presented a day-long program in Grand Forks attended by 115 people, including doctors, nurses, mental health clinicians, educators, therapists and families.

Wang took participants through the NMT theory and how the methods can be used in different settings such as hospitals, schools, families and foster homes. Participants also had hands-on skills building to integrate NMT methods into their treatments.

Evaluation by the participants was very high, with 94% saying after the presentation that they better understood children and youth who have experienced trauma and why they may act/re-act in the ways they do. And 93% said that after the presentation they knew more about how to interact with children and youth who have experienced trauma.

NMT'S SIX RS OF TRAUMA-INFORMED CARE

- **RELATIONAL** — safe
- **RELEVANT** —developmentally matched
- **REPETITIVE** — patterned
- **REWARDING** — pleasurable
- **RHYTHMIC** — supports neural patterns
- **RESPECTFUL** — of child, family, culture

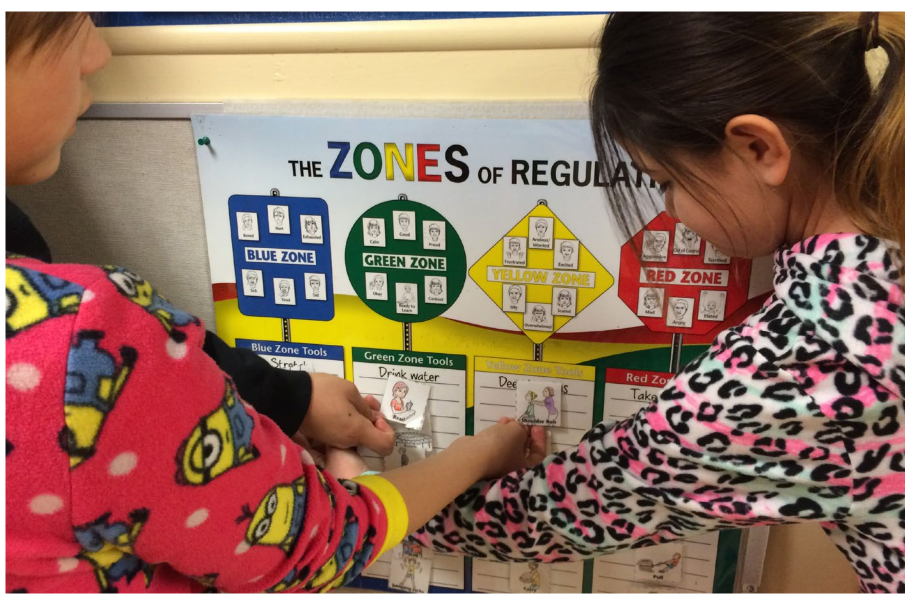
CARING, COMPASSIONATE CONNECTIONS IN THE CARIBOO

What does a trauma sensitive school look and feel like? At the Marie Sharpe Elementary School, in central Williams Lake, it means, for example, when a child comes late to school, instead of a reprimand, everyone — from the principal to the teachers to the secretaries and even the custodial staff — says: "Welcome, I am glad you could come."

"Detentions, punishments, repercussions simply don't work — and may re-traumatize a child who is already suffering," notes principal Calvin Dubray.

For the last 18 months Dubray and his staff have been going all out to create a trauma-sensitive school for their 185 "inner city" students, of which 67% are First Nations. This means the school has taken a whole school approach to understand not only the educational impacts of trauma but the social and emotional impacts, too.

It means they have created a safe supportive environment where students make positive connections with adults and peers that "they might otherwise push away." It means it is a school where students learn how to calm their emotions allowing them to focus and settle and feel confident enough to engage in learning, Dubray notes.



Children at Marie Sharpe Elementary School in Williams Lake work with the Zones of Regulation board to help learn how to regulate their emotions. Photo: Calvin Dubray

"We knew we had to do something different. We had children with behavioural and emotional challenges that were trauma-based," said Dubray. The behaviours "ran the gamut" of swearing, fighting, pushing, running away, refusing to comply with adults, temper tantrums, nausea, wetting pants, crying and more.

Dubray, and Silvia Seibert-Dubray, Director of Instruction for Support Services for the District, are both members of the **Cariboo LAT.** Another LAT member, Larry Johannessen, a former school counsellor at Marie Sharpe, brought the information about the trauma-sensitive schools movement to the Dubrays' attention. "My staff and I are frontline — even some of the staff have trauma in their background," Dubray said.

The LAT also helped bring key people together to foster discussions about trauma and make the connections, including providing support to submit a grant proposal to the Ministry of Justice for seed money for educational materials. The LAT has also supported Dubray to develop a toolkit for creating trauma-sensitive schools, complete with resources and implementation guidelines, that soon will be available.

At Marie Sharpe, all school staff — not just teachers but also educational assistants, secretaries and custodians —received in-depth training and discussion on the impact of trauma on the developing brain and how

TRAUMA-SENSITIVE OR TRAUMA-INFORMED?

Some literature around trauma's impact makes a distinction between "trauma-informed" and "trauma-sensitive." What's the difference?

According to the US Trauma and Learning Policy Initiative, "trauma-informed" is the term they apply to the approach doctors, therapists and other health care providers take in treating and working with clients with trauma in their histories.

"Trauma-sensitive" is the one they prefer being applied to communities, especially schools, recognizing they are not in a specific therapeutic role, but are creating an entire culture — whether in a school or a whole community — that aims to have all feel safe, welcomed and supported. (See traumasensitiveschools.org)

Silvia Seibert-Dubray notes at Marie Sharpe School in Williams Lake they deliberately chose to call themselves a trauma sensitive school based on that definition.

to provide a warm, welcoming place where children learn to trust in relationships and experience a calm, structured, and predictable environment.

Over the last 18 months a complete culture shift has occurred at the school, Dubray notes. "The biggest change is in the way the staff relates to the students," Dubray said. "You can't get anywhere with the learning if you don't establish a relationship. For some of our students this is now the safest place they know."

Among its holistic approach, the school has a breakfast club, a snack program, a modified lunch program and a back-pack program that sends food home for weekends, all to meet the needs of children who may come to school hungry. They also have a program that provides donated warm clothes for winter weather.

The school has also adopted a "Zones of Regulation" program (see zonesofregulation.com) in which children learn how to better identify and regulate their emotions by recognizing various emotional states in themselves and others. The school has a regular contest featuring posters with pictures of teachers for which the children identify the emotional states depicted: green is for calm/happy; blue is for sad/down; yellow is for keyed up/anxious/antsy; red is for angry/terrified/out of control. "What helps you get back in your green zone?" is a question that is continually asked of staff and students.

"Now there's a conversation, sharing how they get themselves into the green zone, what strategies they use," Dubray said, noting even parents are now talking about "getting into the green zone," too.

Teachers regularly do breathing and relaxation exercises, meditation and yoga-like stretches in the classroom to settle and calm the students after lunches and recess. The school has also created a "sensory-mindfulness room" that is full of objects to touch, hold, and "fidget" with, as well as a big crash mat and a mini trampoline to help kids who are feeling anxious or antsy.

The school is also providing programs for vulnerable parents to get support, creating their own caring relationship with the school.

"It is all about coming together as a community, recognizing that this is important, then providing support for the schools to do it," Dubray says. "Schools often are all about the curriculum, but children won't learn if they don't feel safe. We have to work on the heart before we work on the head."

TRAUMA-INFORMED PRACTICE GUIDE

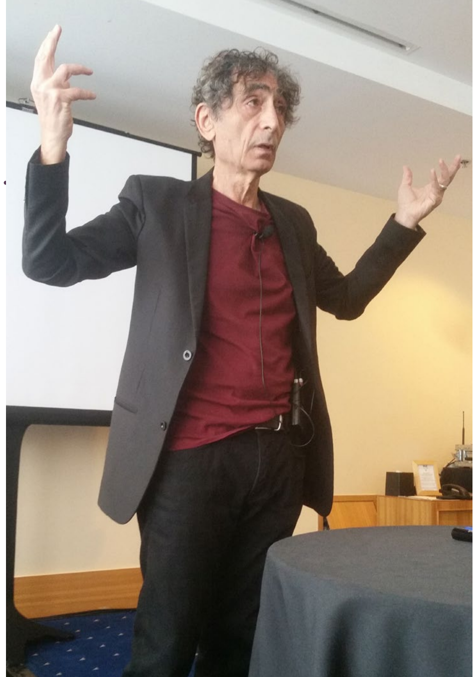
The Mental Health Faculty has created a guide to assist Collaborative members to find resources for trauma-informed care. The guide contains information from provincial, national, and international sources and summarizes what is happening in BC. It lists other trauma-informed guidelines and sources for information about ACEs, child developments, training programs, and supports for educators.

SEEING THROUGH A TRAUMA LENS

Over the last three years the **Cariboo LAT** has undertaken a number of events and initiatives to increase trauma-informed practices and trauma-sensitive environments in their region. With one of the highest concentrations of First Nations in the province, second only to the Northwest Coast, Williams Lake and surrounding communities have many children, youth, and families who have experienced significant intergenerational trauma from the aftermath of colonization and residential schools.

In the spring of 2016 the LAT invited noted author and addictions expert Dr. Gabor Maté to address the community. Maté also spoke passionately about the impact of ACEs at Learning Session 7. In Williams Lake he gave a session with clinicians about his approach to trauma-informed addiction issues. As a physician for more than a decade in Vancouver's Downtown Eastside, Maté says in his presentations that he rarely if ever has had a patient with addictions issues who did not have trauma or neglect in his or her history. "Addictions do not originate in the substances people use, but in the trauma they endured," Maté said.

In November 2016 the Cariboo LAT also held an informational session with Evelyn Wotherspoon, a Calgary-based social worker who specializes in helping children and families at high risk for ACEs. Ms. Wotherspoon detailed how a child's early development can be derailed from adverse experiences and how a community could foster early intervention through caring, compassionate connections.



Dr. Gabor Maté spoke about trauma and addictions at Learning Session 7.

UNBC'S NORTHERN TRAUMA PROGRAM HOLDS WORKSHOPS FOR NORTHERN LATs

"I am passionate about mental health and wellness for Northerners and the connection to adverse events," says Dr. Linda O'Neill, an associate professor and researcher at the University of Northern BC in Prince George, as well as a practicing counsellor and certified trauma specialist.

O'Neill is also a co-founder of the Northern Trauma Program and Compassionate Practice North, which focuses on developing and presenting workshops and training programs for teachers, schools, and health care providers on trauma-informed practice.

During 2016, three LATs hosted one and two-day trauma-informed workshops led by Dr. O'Neill, in which more than 350 people in the north received greater training and exposure to trauma-informed practices, particularly in creating trauma-informed schools that are safe, welcoming, calm and predictable.

In June 2016, **Smithers LAT** sponsored a day-long workshop on a Pro-D day with O'Neill on trauma-informed schools with more than 120 attendees, including teachers, school counsellors and principals from Smithers and nearby Houston, and the district superintendent.

"It was incredibly inspiring. Teachers said it was the best Pro-D they had ever had," said Cheryl Hofweber, project lead of the Smithers LAT. Smithers is continuing to work with Dr. O'Neill and aims to further embed trauma-informed practices in the region.

In November the **Vanderhoof LAT** and then in December the **Dawson Creek LAT** both held two-day workshops led by Dr. O'Neill, with more than 250 people attending — including school counsellors, teachers, support staff, social workers, physicians, therapists, foster parents, recreational staff, and more. "We wanted to blanket the community with this training because we feel it is vital information," said Martha Funk, project lead of the Dawson Creek LAT. "Dr. O'Neill was a fabulous, engaging presenter."

Clearwater LAT is planning a two-day seminar with Dr. O'Neill for Fall of 2017 for care providers in Clearwater, Barriere, and Blue River.

O'Neill notes that trauma-informed practice does not require that individuals disclose trauma, but rather that the system itself focuses on safe practices and healthy relationships to assist people to live lives less defined by traumatic experiences.

O'Neill and her research team have compiled a practical 40-page manual "Trauma Informed Classroom Strategies," which includes evidence from global literature and provides clear, direct advice and actions for elementary schools who want to implement trauma-informed practices — from how to deal with triggered responses to how to foster competence and resiliency. The manual is available as a free download by Googling: O'Neill "Trauma Informed Classroom Strategies." Her team is currently working on the development of a manual for secondary schools focusing on adolescents who've had adverse life events.

L-R: Cheryl Hofweber, of the Smithers LAT, co-leads a Bear's Den about Trauma-Informed Practices at Learning Session 8. A helpful guide is available from UNBC's Northern Trauma Program, led by Dr. Linda O'Neill.

OTHER TRAUMA-INFORMED ACTIVITIES

MERRITT AND CAMPBELL RIVER LATs

Both LATs approached trauma from a First Nations perspective. Merritt hosted a day-long "Mobilizing Community" workshop in September with registered psychologist Darien Thira, a specialist in Aboriginal grief, trauma and healing, particularly around suicide in First Nations communities. In October 2016, Campbell River LAT held a workshop for educators that included presentations on trauma from a First Nations traditional perspective.

LYTTON LAT

The Lytton Elementary School website notes that all but four of its 75 young students are of Indigenous ancestry, with the majority having parents or grandparents who grew up in the Residential School system. "The impacts of their experience at Residential School are felt throughout our school and community," the school notes. In November 2016, the Lytton LAT decided to honour the resiliency of the community and its natural helpers and champions. It hosted a community dinner to honour more than 35 Community Champions of Wellness, who contribute to the wellbeing of children and youth in small and big ways. The Champions were nominated by Lytton children, youth, and adults working closely with youth, who saw them as people of trust who help build resiliency, and could be relied upon in times of crisis. More than 130 people came out to recognize the Champions as community leaders and bridges to young people in Lytton. Not all of the Champions were known to local service providers or LAT members. This event helped to extend the list of resource people who were available to support children and youth.

REVELSTOKE LAT

Since the impact of trauma can be held in the body — such as difficulty taking a deep breath, clenching jaws or wringing hands, or inability to stop intrusive thoughts — trauma-informed yoga is a burgeoning practice to combat the effects. Yoga teacher training on trauma-informed yoga was hosted at the local women's shelter. The LAT provided funding support, with the understanding that the yoga teachers would offer training in the high school, and then support teachers to continue to offer it at the school. Five high school teachers took the training and it is now being offered at Revelstoke Secondary.

GABRIOLA LAT

In November 2016, a two day trauma-informed workshop was held for 21 service providers on the island, including physicians, teachers, school principals, educational assistants, social workers, child care providers, counsellors and ambulance attendants. Co-sponsored by the LAT and a local foundation, the workshop was presented by CAST (Come and Sit Together) Canada, a Peterborough Ontario-based foundation started a decade ago by Tom Regehr, whose former alcoholism and drug addiction was based in undiagnosed childhood trauma. The workshops were developed particularly for frontline care providers in dealing with affected clients. "When I help a social worker or cop or counsellor understand what might be going on in the hearts and minds of somebody who's needing help, my hope is that they're able to be more present, they're able to be more compassionate, and they're able to actually help rather than further traumatize," he says.

FOCUSING ON THE EARLY YEARS: POSITIVE CONNECTIONS, FEWER ACEs

Children from newborns to age six who are raised in safe, healthy, and stable homes with strong attachment to attentive, responsive caregivers not only have a greatly reduced risk of experiencing adverse childhood events, they are also more apt to have a good start in life. Two LATs are engaged in activities focused on promoting strong and healthy early years.

In an effort to foster attachment between newborns and their mothers, and prevent future ACEs or neglect, the **Comox Valley LAT** sponsored the training of six family physicians and one pediatrician on how to spot early attachment issues among new parents —especially mothers who may have been impacted by trauma themselves — and how to provide positive, proactive support to enhance early attachment.

Oceanside LAT recognized that in its community the most vulnerable families do not seek out 'early years' programs and often live in rural areas with poor access to transportation and recreational services. It created outreach pre-school play groups, such as pop-up "picnic and play" events, which connected parents and young children to mentors and resources.

SHINING LIGHT IN A DARK TUNNEL

HOW BC LATs ARE SHOWING YOUNG PEOPLE THAT THEY AREN'T ALONE AND SUICIDE IS NOT THE WAY OUT

OF ALL THE MENTAL HEALTH crises, perhaps none is more bewildering, frightening and heart-breaking than a child or youth who is suicidal. The young person may not really want to die but just to escape overwhelming mental and emotional pain; family and friends feel helpless and don't know what to do to help their loved one.

According to Statistics Canada, suicide among people age 15 to 24 is the second leading cause of death, after accidents. Suicides account for one quarter of the deaths of young people.

No wonder then, that during the CYMHSU Collaborative, more than two dozen LATs have chosen to improve suicide prevention efforts, awareness, and response. LAT actions include suicide prevention and intervention training, awareness-raising events, creating suicide information tool kits, and suicide response process mapping.

These activities, some of which are outlined here, have targeted myths, linked people to key connections, equipped youth and caregivers with skills and intervention techniques, and ensured more youth have access to effective supports.

AWARD-WINNING ASIST PROGRAM SPREADS ACROSS BC

In 2009, the United Nations Education, Scientific and Cultural Organization (UNESCO) named the program ASIST — Applied Suicide Intervention Skills Training — as one of Canada's gifts to the world.

First created in the 1980s by a mental health team in Calgary in partnership with the local chapter of the Canadian Mental Health Association (CMHA), the two-day, skills-building workshop has undergone 11 adaptations and updates in 30 years and won numerous awards. It is now used in more than 15 countries and has become the global standard in suicide intervention training. More than a million people worldwide have been trained in its methods and numerous studies of the program indicate that it significantly reduces suicidality (the risk of someone trying to kill themselves) and increases safety.

In 2016, 14 BC LATs, including nine in the North, supported more than 200 members to take the two-day ASIST program, including doctors, RCMP, school teachers, school counsellors, and others.

"It was very powerful and effective," said Carrie Thorpe, project lead of the **Prince Rupert LAT** and one of 24 people who took the ASIST training in that community in 2016, 14 of whom were sponsored by the LAT. "To have that many people from our small town trained is huge. Now we have 24 more people who know what to do and how to help."

Fort St. James LAT trained 23

members in its small community of 1,600 people. The **Smithers LAT** trained 29. **Haida Gwaii North** and **South LATs** joined together and trained more than 30. Other LATs trained an average of 10 to 15 individuals and include **Burns Lake, Fraser Lake, Prince George, Valemount, Merritt, Golden, Revelstoke, Shuswap,** and **Bella Coola,** which offered it twice. Still more LATs plan to offer the training in 2017.

The program is licensed by the Calgary-based organization LivingWorks (livingworks.net) and is delivered by regional registered trainers, such as the local CMHA office, which offers it under its Gatekeepers program. Two trainers provide a grounding in scientific theory, audiovisual learning aids, group discussions, and skills practice and development.

Many of the same LATs as well as **Long Beach LAT** and **Port Alberni LAT** offered a less-intensive, half-day training program called SafeTALK, also created by LivingWorks. SafeTALK is an "alertness" training program that prepares anyone over the age of 15 to recognize the signs and symptoms of individuals who may be having thoughts of suicide and to help connect them to life-saving interventions, such as caregivers trained in ASIST. In 2016, more than 200 people were trained in SafeTALK skills through support by the Collaborative. A number of LATs plan to offer more SafeTALK training in 2017, particularly to youth members or through local high schools.

SALT SPRING'S TOOL KITS

How do you talk to a youth who has suicidal thoughts? What do you say or not say? Will talking openly about suicide cause more harm than good?

Those are the kinds of questions that many parents, friends, and service providers in BC have when trying to help young people with suicidal thoughts or who attempt suicide. When the **Salt Spring Island LAT** formed in 2015, the group members knew they wanted to address those questions and provide help for suicidal youth on the Southern Gulf Islands. They created three tool kits with the facts, links, local resources — and even specific words — to help a suicidal youth. One tool kit is focused on the youth and their friends; one is for parents and caregivers; and one is for professionals, such as doctors, teachers, and other service providers.

"It really was a communal effort. It was created and reviewed by a lot of people," said Janine Gowans, Coordinator of the Salt Spring Island Chapter of the Rural and Remote Division of Family Practice, which oversaw the project for the LAT.

A SUICIDE INTERVENTION TOOLKIT FOR PARENTS & CAREGIVERS ON SALT SPRING ISLAND

CONNECT

A SUICIDE INTERVENTION TOOLKIT FOR PROFESSIONALS ON SALT SPRING ISLAND

COMPASSION

YOUTH SUICIDE INTERVENTION TOOLKIT

REACH OUT

Practical, direct, jargon-free and evidence-based, the three tool kits share common information such as how to talk to suicidal youth and common myths around suicide, but have been tailored to their specific audience. For example, the professional toolkit includes risk assessment and universal precautions, while the youth toolkit contains the stories of other youth who have come through their suicidal episodes and are now doing well.

The LAT is making the tool kit contents and design files freely available to other BC LATs to customize with their own local information and to share it. "We specifically designed them so the second page could be tailored with the numbers and resources in each region, while the rest of the documents remain unchanged," said Justine Thomson. She is the project lead of the Salt Spring Island LAT and executive director of Need2, a Victoria-area suicide prevention organization, who played a key role in the toolkits' completion.

Mission LAT decided to distribute the toolkit with their resources on the second page. "It makes so much sense not to re-invent the wheel when this is such an excellent resource," said Nicole Martin, project lead of the Mission LAT.

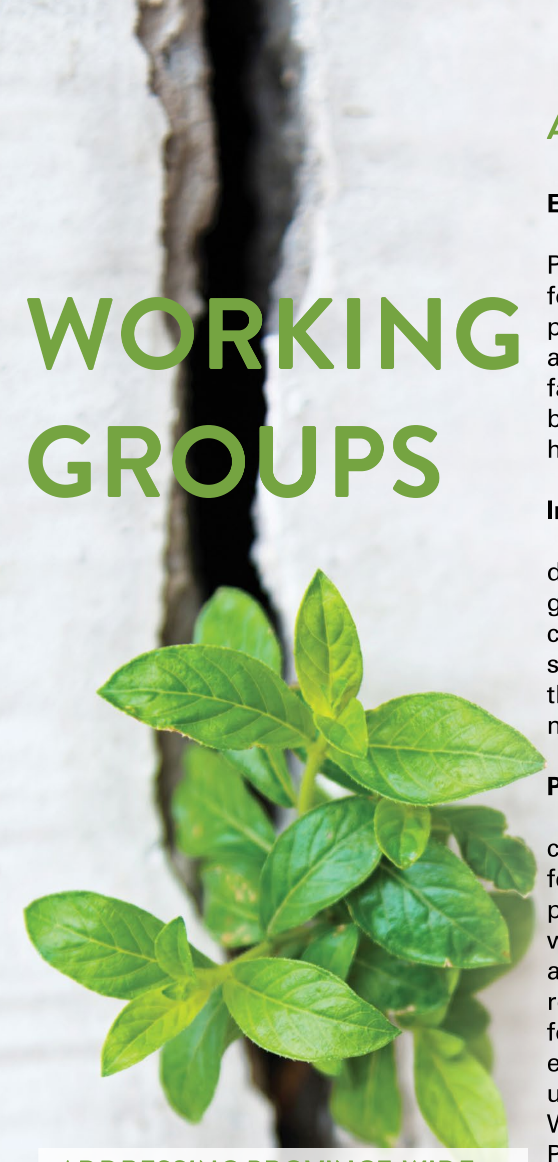
ACTIONS REDUCE SUICIDE RISK

Quesnel LAT: In order to create supportive, system-wide processes to reduce suicide risk in the community of 10,000, the LAT coordinated suicide response process mappings in five organizations: the local ER, the high school, the RCMP, MCFD-CYMH, and the Friendship Centre. Previously these organizations had not been aware of the other's processes or supports for responding to individuals with suicidal thoughts or actions. Now the processes are being coordinated and redesigned. The ER is also redesigning its suicidality protocols.

Shuswap LAT: In honour of World Suicide Prevention Day, the LAT hosted the first Lantern Walk on September 14th, 2016. Carrying lights and lanterns, more than 100 members of the community met in the lakeside McGuire Park in Salmon Arm. As live music played they walked along a park path as a way to remember those whose lives have been lost to suicide, to raise awareness about suicide risks, and to link people to community resources. "It was a beautiful event with an even more beautiful impact," said Sarah Robertshaw of the Canadian Mental Health Association local chapter and a LAT member.

Abbotsford LAT: To also mark World Suicide Prevention Day in 2016, the LAT partnered with Sto:Lo First Nations Health Services for a family fair day to raise awareness about suicide prevention. The LAT provided funding for transportation for youth to attend.

WORKING GROUPS



ADDRESSING PROVINCE-WIDE BARRIERS

System-level gaps and barriers that impede CYMHSU care, which are beyond the scope of LATs to tackle, were passed to 11 Working Groups (WGs) to be studied and addressed at the provincial level.

These WGs worked with the Steering Committee, and Mental Health and/or Substance Use Clinical Faculties to explore the issues and create recommendations for action.

All the WGs aimed to bring together key individuals with knowledge and influence in specific areas. Most had representatives from the Ministries of Health (MoH), Children and Family Development (MCFD) and Education, health authorities, physicians, families and LATs. In most cases, the WGs provide recommendations and in depth analysis of the gaps or barriers, but implementing the suggested changes through policies and practices is in the realm of various ministries or health authorities.

AIMS AND ACHIEVEMENTS

Emergency Room Protocol

16 members. Created a CYMHSU Protocol to standardize best practices for care in ERs in BC, in addition to providing follow-up support plans and resources for children, youth and families in crisis. The protocol is now being implemented in ERs in all five health authorities. See page 50.

Information Sharing

19 members. Bridging gaps in care, disseminating information sharing guidelines, creating a common consent form, and streamlining support across service providers through improved and consistent methods for information sharing.

Physician Compensation

28 members. Recommended changes to compensation and fees to ensure a fair and equitable payment system for psychiatrists, with leadership by Interior Health and psychiatrists in that region. It resulted in a Blended Payment Guide for psychiatrists that was tested and evaluated in the Interior and is now under adoption in all regions. The WG was then incorporated into the Physician Recruitment and Retention Working Group. See story next page.

Transitions – Youth to Adult

20 members. Supporting youth aged 16+ to transition safely and effectively from CYMH services to the adult mental health system. Led by MCFD and MoH, the group has retired now that the developed protocol is with MCFD and Health Authorities for implementation in communities.

Transitions – Hospital to Community

10 members. Ensuring safe and effective transitions for children and youth moving from hospital to community. Led by MCFD and MoH, the protocol will be tested in Spring 2017.

Youth and Young Adult Services

30 members. Identifying and addressing the unique needs of the youth and young adult population (ages 12 to 24), the WG was the reference group during the process of creating five provincial youth hubs (BC Integrated Youth Services Initiative or BC-IYSI) now known as BC FOUNDRY.

Learning Links

22 Members. Developed 15 online, CME-accredited learning modules on child and youth mental health issues to enhance the skills of general psychiatrists, pediatricians, family physicians, nurses and clinicians. See page 51.

Physician Recruitment and Retention

16 members. Working with Ministries, Health Authorities, Doctors of BC and other organizations to improve the recruitment and retention of physicians providing child and youth mental health and substance use care. Resulted in increased training spaces for adolescent psychiatrists, created an exit interview template for psychiatrists, and conducted surveys of physicans. Their work also led to a request for the creation of a new set of fees for GPs with CYMHSU skills.

Telehealth/Rural and Remote

23 members. Building community capacity by supporting the standardization and utilization of technology to improve access to mental health and substance use services for children, youth and families in rural and remote communities, including Aboriginal communities. Created a report, released in March 2017, with eight key recommendations. See opposite page.

Building MHSU Capacity in Schools

18 members. Identifying and building relationships with organizations providing MHSU support in schools, to increase awareness and capacity for stigma reduction, early identification and support for children, youth and families with emerging MHSU issues.

Evaluation and Measurement

20 members. Developing a framework and providing oversight for an evaluation that examined qualitative and quantitative data from LATs and WGs and included case studies, assessments of key initiatives and key informant interviews. This magazine, *Legacy*, is its report.

COMPENSATING DOCTORS FOR CYMHSU CARE

One barrier to province-wide services for children and youth with mental health and substance use issues is the rules, regulations, and available fee codes for physicians to be adequately and sensibly compensated for the care they provide.

"There is a significant link between negative patient experiences and barriers to physician compensation," said Kayla Gowenlock, manager, Medical Affairs & Clinical Networks for Interior Health, who co-chaired the 28-member **Physician Compensation Working Group**.

For example, pediatricians often need to communicate with parents to get an update or discuss a course of treatment for their child, but in order for the doctor to bill for services, the child has to be at the appointment too — meaning the child is pulled out of school or other activities. The working group recommended, instead, that new consultation fees be created that allow various forms of telephone consultations, or subsequent meetings with parents and caregivers in which the child is not present.

"We tried to pull together the right people to have the level of influence to make the changes needed," said Gowenlock.

Thirteen organizations were represented on the working group including Interior Health, Ministries of Health and Children and Family Development, Doctors of BC, Shared Care Committee, Specialist Services Committee, and GP Services Committee, the Practice Support Program, BC Psychiatry Association, BC Pediatrics Society, Provincial Health Services Authority, First Nations Health Authority, and practicing psychiatrists, pediatricians and family physicians.

After extensive discussion and exploration of the issues, the WG created a 38-page report with 26 recommendations, including recommendations for changes to certain fee codes and the implementation of a new guide they created called the Psychiatric Blended Billing Compensation Guide. The guide outlines when psychiatrists should bill for "sessions" and when fee-for-service.

"The blended billing guide was a huge piece of work — it has never been done before. It was quite an achievement to create a document, endorsed by all parties, that clarifies what the process and rules are between sessional and fee-for-service billings."

The Specialist Services Committee incorporated all five of the Working Group's recommendations for fee changes into a broader strategy, which was approved and implemented in November 2015. The BC Psychiatric Association made changes to their Section's fee codes in January 2016 which aligned with some of the WG's recommendations.

The Working Group has now been absorbed by the **Physician Recruitment and Retention** (PRR) Working Group, where compensation issues are part of a whole strategy to attract and retain child and adolescent psychiatrists, pediatricians and family doctors with enhanced CYMHSU skills. The advocacy of the PRR Working Group increased the specialist training positions at the University of BC for child & adolescent psychiatrists from three to four positions in 2017/18 as well as created an exit interview process to learn from any psychiatrists leaving their position. The PRR Working Group has also made a request to the Shared Care Committee that a new set of fee codes be created to support GPs with enhanced CYMHSU skills to work in school clinics or youth hubs.

PROMOTING EQUITABLE, SUSTAINABLE AND EFFECTIVE TELEHEALTH IN BC

Imagine a youth with obsessive compulsive disorder in a remote region of BC attending a special group therapy session at BC Children's Hospital in Vancouver by video link up with their MCFD clinician by their side. The youth would get the therapeutic benefit of group therapy for OCD while the clinician gains more exposure and experience to the BCCH's evidence-based approach to treatment.

That's one of the visions of the Collaborative's **Telehealth Working Group**. "We are really trying to make services more accessible and better support CYMH teams in rural and remote areas," says Dr. Susan Baer, child and adolescent psychiatrist at BCCH and the working group's co-chair.

Mental health consultations by telehealth have been increasing in BC, especially in the North, but the coverage is neither consistent nor equitable, notes a new report by the 23-member Telehealth Working Group. The group includes representatives from regional and provincial health authorities, First Nations Health Authority as well as MCFD and BCCH. It conducted extensive research about what helps and what hinders successful telehealth to support MHSU care in BC's more rural and remote communities.

The group's newly released report, *Increasing Access to Mental Health Care for All Children and Youth in British Columbia* establishes three principles: 1) equitable access to telehealth services; 2) effective delivery of high quality telehealth services, and 3) sustainability of services, including the integration of telehealth into community systems of care.

The report makes eight recommendations, including creating standardized community funding to support telehealth; using standardized secure technology; and using telehealth to build community capacity for local mental health services.

A key recommendation is that individual Child & Adolescent psychiatrists create relationships with specific communities, not only doing telehealth consultations but also regularly visiting the community to make personal connections with both care providers and patients.

ER PROTOCOL

NEW PROTOCOL ARMS BUSY ER STAFF WITH TOOLS FOR ASSESSMENT, SUPPORT AND FOLLOW-UP

MANY PARENTS AND YOUTH with mental health struggles can share stories of going to their local hospital emergency room. For most, it was because they were desperate for help or had no idea where else to go.

"It was 11 pm. My daughter was suicidal. I didn't know what else to do," recalls one mother.

But for many, the ER visit often increased their frustration and sense of isolation.

"We sat in the ER for 14 hours. Then they interviewed us, told us she was high risk, told us to keep ropes and pills away from her, and then sent us home. That made us feel more alone than ever."

Another youth described going to the ER when a deep cut from self-harm needed stitches. "I knew I needed more than just stitches — I was lost and really scared. I wanted help to stop cutting but I had no idea where to go. But the doctor who stitched me up made me feel like I was wasting his time and he wanted me out of his ER fast."

Busy ER physicians and staff have their frustrations, too. "My colleagues were saying: 'Give us something that we can use, so that we know what to say, what to do, so that we can get these kids managed properly," recalled Dr. Jeff Peimer, an ER physician in Williams Lake, BC.

The challenges of the current ER system for young patients, their families, and ER staff were the impetus for the creation of the **Emergency Room Protocol Working Group** (ERPWG), of which Peimer was a key champion.

Formed in the summer of 2013 soon after the Collaborative started, the ERPWG's mandate has been to improve the experience of children, youth, and families with mental health and substance use challenges who arrive at BC ERs and to create a standardized approach to their care. Along with Peimer, its members include three psychiatrists, another ER physician, health administrators, school counsellors, and MCFD staff.

The protocol covers four key areas to ensure support and follow-up. See box, opposite page.

An ER protocol has been badly needed. According to the Canadian Institute for Health Information, between 2005 and 2014, ER visits for

mental health issues for children and youth age 5 to 24 increased by 45%, whereas rates of ER visits for all other conditions among this age group remained stable. Increases in BC may be even more dramatic. The Penticton Regional Hospital reported that between 2013 and 2016, the number of children and youth who came to their ER with mental health concerns increased 75%. Child Health BC notes depression, suicidality, and self-harm are among the top reasons why youth aged 10 to 17 years arrive at the ER.

Regional training for ER staff was offered early in the process to generate interest, followed by community-based training sessions that were delivered in person and online. To date 375 people have attended training sessions in the Interior alone.

The ER protocol is gaining momentum and being implemented at sites in all five regions of BC. At most sites, the ER protocol is being tested in tandem with a new assessment tool created by experts at BC Children's Hospital, called HEARTSMAP. The tool, named for its acronym, assesses 10 psycho-social variables: Home, Education and activities, Alcohol and drugs, Relationships and bullying, Thoughts and anxiety, Safety and sexual health, Mood and behaviour, Abuse, Professionals and resources. The HEARTSMAP tool fits into the larger protocol process.

The ERPWG aims to have the protocol implemented in the majority of BC's 109 hospitals by December 2017. Already it is gaining traction, as administrators adopt it as their standard protocol, rather than viewing it simply as a pilot. As Health Authorities review and implement the ER Protocol in specific sites, it is generating discussions within ERs across the province about how they provide support and improve care.

Evaluation results are not yet available. Anecdotally, the early response is that children and youth exposed to the protocol in select ERs are benefitting. Debra Salverda, who was a nurse clinician with Interior Health's Community Crisis Response Team, noted that in Penticton, a 15-year-old boy showed his safety plan from the ER protocol a month after his ER visit, pulling it out of his wallet. "I was surprised. This demonstrates that the plan is valued and read by kids, and that is what is really important."

The protocol covers four areas to ensure support and follow-up:

1. A pamphlet for youth and families on what to expect that also lists helpful community resources;
2. An algorithm, with assessment tools, to guide the ER staff in best-practice care of the youth;
3. A communications plan to link the child or youth back to community resources;
4. A safety plan so that on discharge the family knows what to do at home.

*Learning*Links

When doctors graduate from medical school, most have had only a few hours of training about how to assess, treat, and manage common child and youth mental health concerns.

"Physicians were telling us, 'we are seeing kids every day. We really need more training,' "said Dr. Jana Davidson, psychiatrist-in-chief at BC Children's Hospital.

That's why, as part of the CYMHSU Collaborative, BCCH's Mental Health and Substance Use Programs developed Learning Links, an online series of 15 education modules. The series supports BC pediatricians, general psychiatrists, ER physicians, family doctors, and clinicians in the delivery of evidence-based assessment, treatment, and consultation services.

The modules cover anxiety, depression, self harm, suicidal ideation, eating disorders, obsessive compulsive disorder, schizophrenia, substance abuse, psychosis, and more. One module even covers somatization disorders: the physical ailments such as stomach aches, fatigue, breathlessness, and headache that are symptoms of mental health issues, usually anxiety and phobias.

The content follows a clinical template from presentation through diagnosis, pharmacology, and management. Each module includes instructive video clips, such as how to build rapport with young patients and families. As well, each offers links to other resources and more in-depth medical information. The free modules track progress and can be applied towards self-learning and self-directed activity credits for specialists and family physicians.

"They are very well done. I highly recommend them," noted Dr. Francine Ling, a Nanaimo-area pediatrician and one of the 28 pilot testers in winter 2016.

An evaluation found the majority of pilot testers reported that the modules increased their understanding (85%), ability to identify (89%), ability to treat (82%), and confidence in treating (85%) child and youth mental health and substance use disorders. These findings held true even six months later.

In Fall 2016 Learning Links was released to all interested physicians in BC. By February 2017 feedback had been received from 162 physicians and other mental health service providers who had taken one of more of the modules. Of those, 97% said the modules helped them better understand the disorders and 92% felt more confident managing children and youth with the conditions.

See learninglinksbc.ca

EQUIPPING GPs WITH **CYMHSU** SKILLS & CONNECTIONS

IN LATE 2015, DR. JILL CUNES, a family doctor in Golden, BC, was one of half a dozen GPs in her region who signed up for the Practice Support Program Child and Youth Mental Health module. As one of 12 physicians working in the only health clinic in town, she and her colleagues cover all the health needs of the surrounding population. Since joining the clinic in 2013 she's noticed an increasing number of youth and young adults coming forward with mental health and substance use concerns.

"I am not sure if it's a true increase in incidence, or whether it is simply more youth being aware and seeking help," notes Dr. Cunes, a member of the **Golden LAT**. Nevertheless, since the need for care has increased, she wanted to keep current so signed up for the module.

Enabling family physicians to have up-to-date skills and knowledge was one of the key reasons the Practice Support Program (PSP) developed and released the CYMH Module in 2011.

Established in 2007 under the Joint Collaborative Committees of Doctors of BC and the BC government, the PSP's provides a suite of evidence-based educational services and in-practice supports to improve patient care and doctors' experiences. One of 11 training modules created by PSP, the CYMH module is primarily aimed at family doctors to support them to identify, assess, manage and treat children and adolescents with mild to moderate mental health disorders, specifically anxiety, ADHD, and depression.

The module's goal is to improve physicians' knowledge and aid their collaboration with other parts of the child and youth mental health system, such as with pediatricians, local mental health service providers from the Ministry of Children and Family Development, psychiatrists, and non-government community agencies. During the module, these allied professionals are invited to attend the sessions and present to doctors about their specific services.

Cunes found that the PSP module was a valuable use of her time, connected her to other care providers in the region, and updated her with screening tools and algorithms for care.

"I really believe in keeping up-to-date with regular CME (continuing medical education)," she said. Her colleagues share that view, she notes, as the majority of them have also taken the PSP-CYMH module since its debut.

The module was a pivotal precursor to the establishment of the CYMHSU Collaborative — for doctors and other service providers who attended it in the Interior, it identified the gaps in care, and spurred them to find solutions. This seeded the Collaborative, bringing together multiple partners to take on some of the issues.

Since the Collaborative started, more than 1600 doctors and Medical Office Assistants in BC have taken the module. As well, at least 10 LATs have made promoting participation in the module one of their objectives.

The PSP program administrators note that since 2013, the CYMH module has been held a total of 92 times in the five health regions.

An evaluation by Hollander Analytical Services in June 2015 found that of the GPs who completed end of module surveys, 96.1% agreed or strongly agreed that attending the CYMH module had helped them improve the care they provided to their CYMH patients.

PSP CYMH MODULE 2013-16

1026	General Practitioners
567	Medical Office Assistants
51	Specialists
250+	Allied Health professionals*

**estimate as numbers not tracked.*

 # OF MODULE TRAINING SESSIONS:

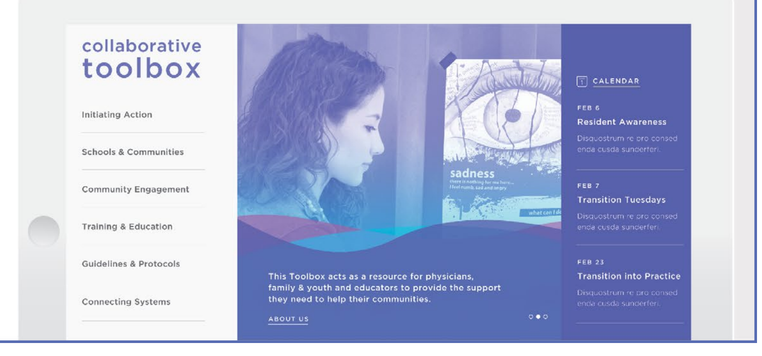
31	Fraser Health region
34	Interior Health region
11	Vancouver Coastal region
14	Island Health
2	North

Source: Doctors of BC, Practice Support Program

collaborative toolbox

Fostering connections, promoting best practices, strengthening communities

collaborativetoolbox.ca



SHARING AN EXPERIMENT **IN WRAPAROUND CARE**

ON A WEDNESDAY afternoon in January 2017, more than 50 people from LATs all over BC signed onto their computer to attend a special webinar. They were there to learn more about a new initiative in family-centred, wraparound, mental health and substance use care being tested by the **West Kootenay LAT**.

Over the course of 90 minutes, a trio of presenters from the WK LAT took participants through the many steps and stages they have taken to improve care and support for children, youth and families with complex issues.

"When we first started thinking about shifting practice here in the Kootenays we had already been together as a team for three years and the relationships were strong enough that people said we're ready to go a bit deeper here," noted LAT project lead Rachel Schmidt.

Key challenges they have had to address include how to shift the values and practice of multiple service providers to one that is more family-centred and strengths-based, with the family and its support networks acting as equal partners at the table. This approach also must respect the expertise of community-based service providers who deliver the wraparound care.

Along with Schmidt, one of the presenters was Dr. Barry Trute, a Canadian expert in family-centred practice now based in Nelson, BC who was hired a year ago to mentor and support the wraparound initiative. Dr. Trute created the *Handbook for Service Providers: Family-Centred Child and Youth Programs and Wraparound Care* that outlines the family-professional partnership that is at the heart of the model. Trute described it as a fundamental culture shift that gives the youth and family "voice and choice."

Key components of the wraparound model are: a strength-based approach that starts with what is currently working well with the youth and family and builds on that; a team of supportive individuals, both professional and personal, that surround the youth; youth and family choice about who is on the team; resource coordination and navigation; and parent coaching.

Described as a pilot, the initiative now has 13 youth and families receiving wraparound service. Outcomes are being tracked and evaluated to help make the case for sustaining the approach. The team is working to ensure they can learn and support the practice in their community through the help of wraparound resource coaches. Isabelle Herzig, the third presenter and one of two part-time wraparound resources coaches, is helping to test and coach others in how to support wraparound care in their community.

Herzig described how one youth in the initiative had previously had four hospitalizations, but since receiving wraparound care, had none. She also described positive family responses, from previously feeling "lost at sea" to now having "a map to a safe harbour."

A number of LATs expressed interest in trying to provide family-centred wraparound care in their own regions and asked about budget, logistics of planning and coordinating meetings, and how to provide wraparound care in rural and remote locations of BC with few care providers.

Dr. Trute acknowledged implementing the model is challenging in communities with few service providers and limited resources. The wraparound team is planning to expand the number of existing service providers who are trained in the wraparound approach. In addition, they are about to embark on a process of training caring adults in three different communities to volunteer to work with families without family supports of their own. Having service providers and family volunteers all on the same page is one way of spreading the model, the team noted. In true collaborative fashion, all the resources developed by the WK team are openly shared with other teams across the province and have been accessed by many.

Q&A With Dr. Jana Davidson

FORGING A CLEARER PATH
FOR THOSE WITH COMPLEX NEEDS

An estimated 5.4% of children and youth with mental health and substance use issues will have more complex and challenging conditions that require a higher level of ongoing specialized expertise. That's about 400 children and youth aged 19 or younger a year in BC. One of the Collaborative activities at the provincial level has been to clarify pathways for children and youth with complex needs, especially those from outlying areas, as they move to higher levels of care. We talked with Dr. Jana Davidson, Psychiatrist-In-Chief, BC Children's Hospital, and Head, Division of Child & Adolescent Psychiatry, UBC, about this process.

What is a complex care pathway?

It's a clear, well-understood process for how a child or youth and their family and their local care providers access higher levels of regional or provincial services to manage the complexity or severity of their mental health and substance use concerns. It could be to obtain an assessment and diagnosis or to receive more specialized treatment.

Why do we need to clarify complex care pathways in BC?

Good care for children and youth with complex mental health issues is available in BC right now, but how to access it is not as visible as it ought to be — to both families and care providers. The many resources that are available regionally and provincially are not well understood throughout the province.

Is there a difference between a complex mental health problem and a severe one?

There's a lot of discussion around this, but yes. Somebody could have a severe illness, like psychosis, and be greatly impacted by its symptoms, but respond well to treatment and be managed well in their local community. A complex case is when multiple issues need to be teased out. What makes that situation complex

is not necessarily the diagnosis or the symptoms, but the interplay of multiple factors underlying the child's symptoms and behaviours.

What is your role on this project?

As head of the Child, Youth and Reproductive Mental Health services at BC Children's Hospital within the Provincial Health Services Authority, I have a responsibility to ensure our partners in the communities know who we are, what our expertise is, and how we can work with them in identifying, diagnosing, and managing some of these highly complex presentations.

How has the Collaborative helped this process?

It's created the relationships and partnerships throughout the province in a way that's never happened before. It's raised the issue of complexity and provided the momentum and infrastructure to work on clarifying the pathway. Without the Collaborative, I don't think we would've had the relationships in place and the connections necessary to do it.

What are the main challenges?

Time — how much time it takes when we are all so busy doing our regular work. And crossing organizational boundaries. We're working with different organizations, different ministries, and the minute you cross a boundary you're running into issues of mandate, issues of budget; we're having to break down silos and come together in ways that make sense and figure out how to get a child or youth the care they need.

Will this create one pathway, or multiple pathways depending on the mental health or substance use issue?

One simplified pathway. We have centralized intake at BCCH. Ideally, a referral comes in and we get together as a team here to coordinate the resources that best meet the needs of this particular child, youth, and family.

Does a complex care pathway mean the child or youth ultimately will have to leave their community?

No, not necessarily. In the past too many had to come down to BCCH to get that care. We hope to change that by providing more support to the care providers in their communities. We can do that in a variety of ways like indirect expert consultations, telehealth, and other supports.

What's the role of the youth and family in the pathway?

They're at the centre. It's all about them. We'll rely on them as partners to identify what's working and what's not working. The pathway is meant to ensure that children, youth, and families get the services they need, where they need them, when they need them, for as long as they need them, by the right people. So we will rely on the youth and families to help us understand how we improve or modify the pathway. If it's not working for them, the pathway is not working.

Is information sharing between care providers an issue in the complex care pathway?

No, not once people are talking to each other. Information sharing is an issue if people don't know who they're talking to and what their role is in the care. That's why clarifying the pathway is important, because if the pathway is clear then people understand the role of others going up and down that pathway. This helps allay the anxieties about what information is needed to be shared as part of the child or youth's ongoing care.

Can you give an example of where we are seeing a complex care pathway already working?

A really good example is the East Kootenays and the new approach to eating disorders care. Through the work of the LAT and the Collaborative, they have improved local resources by tapping into the expertise of BC Children's Eating Disorders program. Now they are able to support most of the youth with EDs right there in their community. (See page 38.) They now have a system in place to identify these kids earlier and treat them earlier so that they are more successful in their initial treatment. And because of that the referrals from them to BCCH have dropped right off. But when they get a really complex case, there's a clear pathway for them right into our program, to either get support or to get that kid to Vancouver. Then, when the youth is discharged, the EK team can provide follow up in their community, with support from us at BCCH if necessary. The Collaborative created that opportunity.

This interview has been condensed and edited.

LATs EXAMINE LOCAL PATHWAYS TO CARE

What pathways to care are available for kids and families with mental health and substance use needs in the community? Are some paths blocked? Do gaps exist?

Finding answers to these questions is the current focus of many LATs across BC. **Fraser Lake, Vanderhoof, Burns Lake** and **Valemount LATs** recently all met together to explore and document shared pathways in their region, which has many small, geographically-isolated communities highly reliant on each other.

"Pathways play a key role in clarifying how MHSU literacy and care function within a community, between communities, and when care is transferred to another community," said Caitlin Blewett, Regional Initiatives Lead for the northern region.

Burnaby LAT is trying a MindMap approach —visually drawing pathways — for youth with moderate to severe challenges that documents their efforts to access care. This approach helps the team to see which pathways are well-defined and which need to be clarified.

New Westminster LAT is developing a resource map that connects service providers, making them more aware of one another and reducing their sense of isolation, as part of a larger pathways project linked with the Fraser Northwest Division of Family Practice.

In 2017, many of the LATs are projected to be working on agreements to create their own community pathways to CYMHSU care as part of a sustainable legacy of the Collaborative.

7 LESSONS LEARNED

The contents of this magazine were compiled through an extensive process of research, document analysis, and consultation. In depth case studies and several surveys were completed, including one designed and implemented by a youth, young adult and family evaluation team. Bimonthly reports from 64 LATs — some 280 documents— were systematically categorized; these categories were then refined and expanded with regional leads and coaches. Information from Learning Sessions and meetings of the Steering Committee, Faculties, and Working Groups were all compiled as were interviews from key participants.

It is impossible to capture every action under the Collaborative umbrella, but the content of this magazine aims to reflect the distinct flavour and range of activities. Some developments were undoubtedly missed. This does not reflect the lack of importance of those endeavours, but rather the challenge of tracking a mammoth undertaking. LATs will continue to tell their own stories of change and to celebrate their accomplishments.

In developing this content, and in sharing it with the Advisory Team listed on the Masthead, a few dominant themes emerged. Summarizing these themes may be useful to the ongoing work of LATs or to any future, large collaborative efforts:

1. YOUTH AND FAMILIES FIRST

Having youth and families at the centre of planning and decision-making produced the best outcomes. Whether it was insight from their lived experience or through partnerships to develop pathways to care, their role was essential.

2. EMBRACE THE COLLECTIVE IMPACT FRAMEWORK

As the Collaborative grew from eight teams to 64, it morphed into a hybrid Collective Impact model, becoming the largest CI initiative to date in BC. Five key attributes distinguish CI initiatives: a common agenda, mutually reinforcing activities, continuous communication, a backbone organization and a shared measurement system. The Collaborative had four of these five, but lacked a shared measurement system across its multiple organizations and regions. Establishing a set of meaningful measures is tough, but focuses actions and outcomes.

3. LATs NEED TO CREATE CONNECTIONS

When LATs played the role of bringing a wide variety of people and organizations to the table to brainstorm, forge partnerships, and go after other funding sources beyond the Collaborative, their impact was greatest.

4. RELATIONSHIPS ARE PARAMOUNT

As LATs formed, a common trajectory marked their growth and development. At the start struggles, uncertainty and mistrust occurred. Teams able to move off entrenched positions and build open, trusting, safe relationships were able to find new ways to work together and achieve new outcomes.

5. SMALL BEHAVIOUR CHANGES REAP BIG IMPACTS

Progress often came from stakeholders changing their own behaviour to create solutions: the MCFD clinician in the East Kootenay who began to walk across a parking lot to see eating disorder patients with the local pediatricians; the Cariboo psychiatrist taking calls from local GPs; the Discovery substance use clinician delivering services in the local school; GPs working with school counsellors to take on teens as patients. These actions all changed the way people worked together, with no extra funding.

6. EFFECTIVE LEADERSHIP IS ESSENTIAL

Collective Impact needs two types of leadership skills: the ability to create a sense of urgency and galvanize others to action; and the ability to create value for stakeholders, keep open to new ideas and work cooperatively while dealing with the fast pace of the initiative. The ER Protocol Working Group's consultation process exemplified both types of leadership skills, as did many successful LATs.

7. SPREAD GOOD IDEAS

Originality was impressive, but the spreading of successful interventions were easy wins. LATs spread, for example, the uptake of Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid training, Indigenous Cultural Competency training, the Blanket Exercise, and trauma-informed knowledge and practises.

We hope *Legacy* magazine, by highlighting some of the Collaborative's accomplishments, inspires everyone to keep working together to continually improve child and youth mental health and substance use services in BC.

LINDA NEHRA

ANNE MULLENS

THANKS TO ONE AND ALL

FROM THE SHARED CARE COMMITTEE CO-CHAIRS:
Dr. Gordon Hoag & Marilyn Copes

It is impossible to truly acknowledge the commitment, compassion, and enthusiasm of the 2,650 people involved in the Collaborative. Whether on Local Action Teams, Working Groups, Clinical Faculties, Steering Committee, or the Joint Collaborative Committees, each has done his or her part in the Collective Impact model, pulling together for a common agenda.

Stewards in government, ministries, regional health authorities, provincial organizations, community agencies, physicians, police, and schools have also nurtured and supported this unprecedented, disruptive undertaking. Youth and families with lived experience have shared their journeys and wisdom and inspired all the activities. There are a number of individuals from behind the scenes, however, who we'd like to specifically mention – **see opposite:**

To all the members of the CYMHSU Collaborative — you have been the heart and soul of the initiative, creating an impact for children, youth and families.

THANK YOU ALL.

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SNAPSHOTS
OF THE
COLLABORATIVE