

Story of Transformation in Youth Mental Health in the Province of New Brunswick

*Dr. Bill Morrison and Dr. Patricia Peterson
Health and Education Research Group
University of New Brunswick*

October 23, 2017



Acknowledgements

- ★ To the Graham Boeckh Foundation for igniting the idea of sharing the story of our transformation of youth mental health services in the province of New Brunswick;
- ★ To Dr. Bill Morrison and Dr. Patricia Peterson, whose wisdom and experience continue to support the positive mental health of children and youth across Canada;
- ★ To Yvette Doiron, Lisa Tracey and Bob Eckstein, whose commitment to youth mental health has been instrumental in the process of transformation; and
- ★ To all who have informed the writing of this story.

We thank you! The support and guidance of so many assists us in further defining our provincial vision.

Government of New Brunswick

Table of Contents

▶	Abstract	5
▶	Part 1: Introduction	7
▶	Part 2: Background: Context of the Story	8
▶	Shared Vision: Goals of Transformation	10
▶	Part 3: Transforming the System	11
▶	Targeted Areas of Transformation	13
▶	Key Elements of Transformation	16
	<i>Provincial Integrated Service Delivery Framework (ISD)</i>	16
	Framework Overview and Goals	16
	ISD Child and Youth Teams (CY Teams)	18
	School and Community Contexts	20
	Integrated Governance and Regional Capacity	20
	Information Sharing and Common Case Plans	23
	Operational Monitoring and Evaluation	24
	<i>Network of Excellence</i>	24
	Overview of the New Brunswick Network of Excellence	24
	Changing the Culture of Mental Health Care	26

Table of Contents

	Developing and Extending the Capacity of the NB Network of Excellence	28
▶	Part 4: Living Change, Transition and Challenge	30
▶	Part 5: Evidence of Transformation	33
▶	Part 6: Lessons Learned	37
▶	Part 7: Expanding Transformation in Youth Mental Health	41
▶	Works Cited	45

Abstract

Within Canadian and international contexts, challenges in accessing youth mental health services have included difficulties in navigating multiple service systems, participation in multiple intake, assessment and case management processes, and experiencing lengthy wait times for services. When such challenges are encountered within systems of care that remain grounded within traditional service delivery models and silos, youth are often denied timely access to intervention supports and treatment. Such realities often lead to increased intensity of mental health needs, heightened stress on individuals and their families, the escalation of emotional/behavioural concerns, and the implementation of more intensive and intrusive intervention responses.

In 2009, New Brunswick's provincial government responded to multiple reports highlighting the need for systemic change related to youth mental health services and supports. The initial design for transformative change emerged from a comprehensive review of evidence for integrated service delivery systems, and direct observation of promising programs and practice models from international contexts (USA, United Kingdom, Australia and the Netherlands) completed by the Health and Education Research Group (UNB).

The recognition of the need for transformation in youth mental health services marked the beginning of a movement of change, shifting from system-centric mental health services toward the adoption of a unified provincial view of placing youth and families at the center of service delivery structures, engaging them as collaborators in the process of recovery and sustained healthy and positive development. Initial efforts included the creation of an inter-departmental provincial committee to work in collaboration with researchers from the University of New Brunswick to design a framework for integrated services for child and youth mental health. The provincial committee was comprised of key leads from the departments of Education and Early Childhood Development, Social Development, Health, and Justice and Public Safety. In acknowledging the necessity for systemic change across youth mental health services, the province conceptualized the *Integrated Service Delivery* framework within a wider *Network of Excellence* (NOE).

The intent of the NOE is to ensure a comprehensive vision of care from which to coordinate, assess and build service capacity that is youth focused and family centered. The development of an integrated and coordinated community care strategy requires collaboration and sharing of resources among a wide range of stakeholders, including those from government, the non-profit sector, private industry and the wider community. The community-based, regional and

provincial services offered within the NOE are contained within a three-level continuum of support that includes universal and prevention services, community-based treatment programs and support services, and more intensive specialized therapeutic services. A foundational principle of the Network of Excellence is its commitment to shifting from a “medical model” to a person-centred, collaborative approach to care. This change in culture places emphasis on the involvement of families in assessment processes and throughout the wellness journey, with *the relationship* as a foundational piece of the intervention story.

A noted strength of the resulting framework was the creation of a regional interdepartmental governance structure, coordinating the operations and integration of services to maximize service capacity to reach more youth at earlier points, and to significantly reduce or eliminate waitlists and wait times. The governance structure represents an *interconnected continuum of services* and supports for youth and families. Selected findings of demonstration site evaluations included a reduction in waitlists for mental health services by 89% and 100% respectively in the two initial pilot regions. The number of youth receiving mental health services within the demonstration sites doubled following the introduction of integrated service delivery practices. National statistics demonstrate that approximately 20% of Canadian youth are affected by mental health concerns; however, only one out of every five youth (4% of total youth) who need help actually receive it. In the demonstration sites, 12% of total youth received treatment in Charlotte County and 8% in the Acadian Peninsula. Operational data from the demonstration regions indicated that youth were being seen at a much earlier point than prior to integration as a result of services being mobilised at the primary and middle school levels.

In September 2016, transformative change in youth mental health was extended to reach 44% of the provincial population. Preliminary data for the 2016 expansion sites indicated that within the first six months of implementation, service access to youth had increased by 52% in comparison to the same time period the previous year for the same regions. Of youth accessing services in these regions, 58% were younger than those accessing mental health in other provincial regions where there was no service integration. As of September 2017, all regions of the province are currently serviced within the mandate of the Network of Excellence.

Part 1: Introduction

Mental health concerns among youth are attributed to a complex interaction of social, economic, psychological, biological and genetic factors that influence overall mental health and well-being. Challenges to accessing appropriate services include difficulties in navigating multiple service systems and participation in multiple intake, assessment and case management processes.¹ When such challenges are experienced within systems of care that remain grounded within traditional service delivery models and silos, Canadian youth are often denied timely access to intervention supports and treatment. Such realities often lead to increased intensity of mental health needs, heightened stress on individuals and their families, the escalation of emotional/behavioural concerns, and the implementation of more intensive and intrusive intervention responses. Existing systems of care must be transformed to work within an integrated youth and family centered paradigm.

The provision of social-emotional supports is seen as a critical component in the well-being of youth with mental health concerns. Among families seeking mental health services for school-aged youth, there is a 40-60% premature dropout rate. Families cite frustration related to disconnected services, and difficulty in accessing community mental health services as two of the main reasons for premature dropouts.²

The recognition of the deficiencies inherent in fragmented models of service delivery has led to a general call for services to be integrated. Integration allows for appropriate services to be delivered to youth efficiently and collaboratively, resulting in decreased service wait times and increased program effectiveness. This approach acknowledges the need for services directed at the whole individual in order to see meaningful mental health improvement based on a wraparound or person-centered approach tailored to meet the specific needs of the individual. Various forms of this approach have been implemented in locations around the world, and studies are showing evidence of benefits related to integrated service delivery models.^{3 4 5 6 7 8}

The provision of integrated services that are outbound and centered in settings that are close to youth and families enhances access and the timely delivery of essential program services and supports. Innovative, integrated school-based mental health service systems have also demonstrated promise for building capacity for prevention and early intervention efforts by enhancing protective factors and minimizing risks related to the escalation of unmet mental health concerns. “Comprehensive school-based mental health service delivery reduces the need for more restrictive and more costly placements, thereby facilitating a decrease in financial costs. Minimizing the need for more restrictive placements also results in fewer separations of these children from their families, friends, and communities”.⁹

Part 2: Background: Context of the Story

In 2009, New Brunswick's provincial government responded to four reports highlighting the need for systemic change related to child and youth mental health services and supports:

- Connecting care and challenge: Tapping our human potential¹⁰
- Connecting the dots: A report on the condition of youth-at-risk and youth with very complex needs in New Brunswick¹¹
- Ashley Smith: A report of the New Brunswick Ombudsman and Child and Youth Advocate on the services provided to a youth involved in the youth criminal justice system¹²
- Together into the future: A transformed mental health care system for New Brunswick¹³

Among the challenges highlighted in these reports, child and youth mental health stakeholders, family members and advocates noted the existence of:

1	Lack of service coordination, integrated intervention planning, matching of service intensity to level of need, and case follow-up processes
2	Participation in multiple intake, assessment and case management plan processes
3	Difficulties in navigating multiple service systems
4	Provision of services outside the family, school and community contexts
5	Impact of families' previous negative experiences with formalized services
6	As many as five departmental files for an individual youth
7	Lack of transportation to access needed services
8	Implementation of more intensive and intrusive intervention responses
9	Heightened stress on families

10	Government departments and other service providers working in silos without a systemic collaborative approach
11	Escalation of emotional/behavioural features as needs of children and youth remained unmet
12	Lengthy wait lists and wait times for essential services
13	Lost educational time to attend appointments
14	Conflicting and competing mandates among service agencies
15	Lack of voice of children, youth and families
16	Transition planning or step-down approaches often left unaddressed

Parent story, prior to integration of services in New Brunswick

“I can’t tell you how many times we’ve taken our daughter to the hospital. When she doesn’t want to live and we’re not sure what she will do, we have to call the police, and each time we end up at Emergency. We tell our story one, maybe two, maybe three times during the time at Emergency. We finally meet with the psychiatrist and get a referral to Mental Health. After a week or so, there’s an initial assessment and we’re placed on a waiting list. As parents, we seem to go in circles. We’re not sure what door to knock on, and we’ve hired private counsellors, which lasts for a time. When we talk about needing to work with the school, or even to plan her free time in the community, there seem to be no connections. How do you make people work together? How do you get a starting point? At this point, we’re still seeking out services, but nothing seems to last very long.”

Shared Vision: Goals of Transformation

Central to the provincial government's response to these reports was a commitment to the transformation of youth mental health services in New Brunswick. A shared vision was elaborated focusing on the positive growth and development of all youth, inclusive of those with complex mental health concerns. This vision entailed partners working together in an integrated manner with a person-centered approach, developing and implementing appropriate and timely interventions based on the strength and need profiles of youth.

This shared vision was centered on service experiences where empowerment, choice and responsibility are promoted within therapeutic relationships and treatment programs with youth and families to ensure the delivery of autonomy-supportive care approaches. The objective was identified as providing a continuum of interconnected supports, ranging from universal and environmental approaches, to the delivery of timely services for areas of emerging concern, and more intensive services for youth with complex mental health needs. The provision of a seamless web of enhanced mental health programs and services was viewed as critical for ensuring a responsive approach for youth deemed at risk or having complex social, emotional and behavioural needs, often exacerbated by unsafe or unstable social circumstances such as homelessness, poverty, conflict with the law and fragile family relationships.

Part 3: Transforming the System: Creating a Framework

The development of a youth-centered framework began with the acknowledgment of a province-wide need to enhance services for youth with emotional/behavioural concerns. The initial completion by the Health and Education Research Group (HERG) of a comprehensive literature review on evidence-informed practices for supporting integrated and collaborative services included a review of internal government reports and evaluations focusing on the delivery of mental health services and supports for children, youth and their families. Notably, it was found that although various studies and initiatives designed to integrate mental health services existed internationally, no model approached the proposed scope of the Integrated Service Delivery (ISD) model, which included the integration of all child and youth services across four provincial ministries, and the delivery of services in the school, home and community contexts.

Promising practices were studied and/or observed in diverse international contexts (HERG), including onsite consultation and direct observation of programs such as the Health Promoting Schools and wraparound movements in Australia; the Ohio Community Collaboration Model for School Improvement in Cincinnati; the Mental Health Services Research Program at the University of Illinois, Chicago; the Research and Training Centre for Children's Mental Health at the University of South Florida; the Community Support and Assertive Community Treatment team in Portland, Maine; and the Flexible Assertive Community Treatment (FACT) team model employed at the Centre for Child and Adolescent Psychiatry in The Netherlands.

Of particular interest to the ISD development committee was the FACT Team model practiced in The Netherlands. Communication with program leads led to an invitation to visit and observe practices at the Centre for Child and Adolescent Psychiatry in Hoorn, The Netherlands. This service delivery model brings together a range of better practices focused on:

- Outbound and community-based services
- Recovery-oriented care
- Inter-professional team practices
- Integrated service delivery among service providers
- Strength and developmentally-focused interventions
- Child, youth and family engagement

The primary goals of FACT Teams are to provide services that match the level of need among children, youth and families with emotional and behavioural concerns, as well as those with more complex mental health concerns. FACT values and applies inter-professional approaches through teams that encompass up to 12 professionals serving a specific community setting or region. Adjusting the level of service intensity based on needs is central to the FACT service approach, which may involve stepping up at times to provide more intensive interventions or stepping down to support the autonomy and self-determination of individuals.¹⁴ While the FACT model incorporated many of the desired components and processes of the proposed ISD model, the Dutch teams were not integrated within education systems, nor were services provided within the school context.

Along with the review of literature and the observation of national and international programs, ISD planning processes also included the execution of multiple consultations and feedback sessions with New Brunswick stakeholders who were to be part of the integrated model, including:

- Regional Health Authorities (RHAs)
- School Districts
- District Education Councils (DECs)
- Departmental directors and professional frontline staff
- Non-Governmental Organisations (NGOs)
- Universities
- Advocacy groups
- Parents, children and youth

Research findings and consultation outcomes were synthesized by HERG to create an initial framework for shifting paradigms, sharing resources, transforming policies and practices related to service content and provision, and the service experiences of children, youth and families.

Targeted Areas of Transformation: Integration of Youth Services

The recognition of the need for transformation in youth mental health services marked the beginning of a movement of change, shifting from system-centric mental health services toward the adoption of a unified provincial view of placing youth and families at the center of service delivery structures, engaging them as collaborators in the process of recovery and sustained healthy and positive development. Initial efforts included the creation of an inter-departmental provincial committee to work in collaboration with researchers from the University of New Brunswick to design a framework for integrated services for child and youth mental health. The provincial committee was comprised of key leads from the departments of Education and Early Childhood Development, Social Development, Health, and Justice and Public Safety.

With the integration of services emerged the need for embracing all service partners in youth mental health in a common mission for building capacity for realizing an interconnected continuum of support for youth and families. Central to this area of development was the inclusion of recovery-oriented perspectives and processes designed to empower youth and family members to be fully engaged in their process of recovery. Such perspectives and practices provide authentic opportunities for youth and families to shape the nature and delivery of mental health services, enhancing both service provision and the quality of service experiences.

In acknowledging the necessity for systemic change across youth mental health services, the province conceptualized the Integrated Service Delivery framework within a wider Network of Excellence (NOE). Current research¹⁵ highlights the efficacy of interconnected system frameworks that address the complex needs of children and youth at risk for or experiencing emotional and behavioural challenges. Such systems focus on the overall wellbeing of children and youth, and minimize access barriers caused by narrow mandates, fragmented service delivery and multiple case planning processes. The NOE addresses these barriers by adopting a holistic, collaborative and seamless approach across all contexts related to the mental health and wellbeing of children, youth and families.

The guiding principles of the NOE's interconnected systems framework are consistent with recovery-oriented services. The recovery approach is fundamental to national strategies in several countries including Australia, New Zealand, the United Kingdom, the Netherlands, Spain, the United States, and more recently in Canada. It is a shared concept that serves to unify mental health and addiction services.

The growing bodies of experiential knowledge and research findings provide concrete evidence that a recovery approach contributes to significant positive clinical outcomes and improvement in overall functioning for persons with addictions, mental health problems and illness, or both. The recovery approach offers hope and the possibility of recovery; it supports families, and involves communities. Assessment and intervention are focused on strengths, and foster hope as well as the development of new skills and knowledge. This approach encourages personal choice and promotes assuming control and maintaining responsibility for one's health to the extent that one is able.¹⁶

The intent of the NOE is to ensure a comprehensive vision of care from which to coordinate, assess and build service capacity that is youth focused and family centered. The development of an integrated and coordinated community care strategy requires collaboration and sharing of resources among a wide range of stakeholders including those from government, the non-profit sector, private industry and the wider community. The community-based, regional and provincial services offered within the NOE are contained within a three-level continuum of support that includes universal and prevention services, community-based treatment programs and support services, and more intensive specialized therapeutic services. These tiers are described below¹⁷.

Universal and Prevention Services

The Network of Excellence recognizes that families who need support should have access to universally accessible programs and services that enhance the development of children and youth, and minimize the potential for later development of at-risk behaviours and conditions. The NOE encourages mobilization efforts of community-based organisations to identify innovative methods for supporting the healthy growth and development of children, youth and their families. In planning universal and prevention continuums of care, four universal needs are considered to ensure the protection of healthy development in children and youth. These include:

- **Basic Needs:** This includes services such as provision of nutrition, economic security, income supports, housing services, adequate shelter and clothing, and basic education, as well as primary health services and quality child care.
- **Nurturing Relationships:** Parents, family members and other caregivers must have access to programs and services that serve to nurture caring relationships with their children including parent education services, parent support and self-help groups, early intervention services, violence prevention programs, as well as programs and services to support divorced or separated parents.
- **Learning Opportunities and Experiences:** Communities must provide children and youth with a wide variety of learning, recreational and cultural opportunities to develop their talents and skills and make positive connections to their communities, cultures, traditions and spiritual resources.
- **Safety and Protection from Harm:** The positive growth and development of children and youth are realized in social environments that are safe and secure, and that contribute to the development of trusting and caring relationships. Key social environments include the home, school, and community settings.

Treatment and Support Services

The key objective of the continuum of treatment and support services is to reduce the duration and/or severity of emotional and behavioural concerns in children and youth through targeted and time-limited services. Such services provide social supports to families experiencing challenging life circumstances and enhance their problem-solving and coping capacities. Treatment and support services may be conceptualized as time-limited, responsive assessment and intervention services that are provided by qualified helping professionals trained to empower parents, children and youth in recognizing and applying their strengths in responding to identified needs or concerns in their present functioning or situation. Within the NOE, treatment and support services are delivered collaboratively between partners, through a common case plan that ensures collaboration with the child/youth and family.

Specialized Therapeutic Services

Integrated clinical teams in each region play a critical role in cases that require acute services by multiple partners by coordinating common case planning and assuring that all possible options are explored in order to support the family's and child's needs before exploring out-of-region or out-of-home options. Prior to providing out-of-home and out-of-region services, efforts are made to utilize all regional capacity, particularly programs offering specialized services while allowing the child or youth to remain at home. Out-of-home tertiary level assessment and treatment services are structured to address the unique needs and referral concerns of each child or youth. The length of out-of-home placements vary according to the level of assessment and treatment intensity required. Services are tailored to meet individual needs, in contrast to a system-driven framework in which every child or youth receives the same assessment protocols and the same level of service intensity.

Provincial Integrated Service Delivery Framework (ISD)

Framework Overview and Goals

The ISD Framework is committed to addressing system gaps in the provision of services to youth with emotional, behavioural and mental health concerns. This is accomplished through inter-professional team approaches that integrate departmental services and programs, and that empower youth and families to be active participants in their process of recovery. A key focus of the framework is the enhancement of system service delivery capacity to respond in a timely, effective and integrated manner, striving to provide the right service, at the right time and at the right intensity in settings that are close to youth and their families. A second and equally important focus of the framework is the creation of positive environments in school and community settings that contribute to the psychological well-being needs of relatedness (being welcomed, known and supported) competency (recognizing and using strengths, and building confidence) and autonomy support (having voice, choice and opportunities to be generous to others). Key goals and desired outcomes associated with the ISD Framework include:

Positive Child and Youth Development

- Enhanced family and community attachments
- Increased school engagement and academic success
- Increased school retention rates
- Decreased levels of high risk/complex needs
- Positive growth and development of children and youth
- Increased diversion of youth from the criminal justice system

Accessible and Timely Services

- Increased awareness of service availability on a continuum among family members and service providers
- Increased identification of needs at earlier stages (prevention and early intervention)
- Decreased wait times for assessment and direct service provision

Effective Case Planning Practices

- Increased continuity of case planning for children, youth and their families
- Increased capacity to adjust service intensity and duration according to child and family needs
- Increased collaboration between partners to ensure multi-disciplinary intervention approaches and integrated ownership of common case plans

Enhanced Relationships

- Enhanced collaborative alliances among service providers and youth and their families
- Increased sharing of information among partners and collaboration with community stakeholders
- Increased job satisfaction among service providers who serve youth, children and their families

System Efficiencies

- Increased coordination of services and resources provided by partners and community
- Increased collaboration between partners in the provision of services and assessments, and reduction of redundancies and duplications
- Enhanced information management processes
- Enhanced regional service delivery capacity

Effective Use of Resources

- Decreased use of out-of-home placements pending assessment and intervention services
- Provision of and access to the right service, at the right time, and at the right intensity

The guiding principles of the ISD Framework assert that the appropriate service delivery intensity must be matched to youth and family needs at all system levels. Emphasis is placed on structuring and managing inter-departmental resources in a manner that allows for flexible and timely intervention responses. Targeted risk/need approaches are complemented and balanced by assessment, intervention and case management practices that draw on the strengths and capacities of youth, their families and the wider community. Person-centered approaches are committed to the engagement and empowerment of youth and their families. In some instances, outreach and advocacy are required to ensure their full participation and collaboration in service provision and case planning activities.

Central to the implementation of the ISD Framework is shared departmental responsibility for ensuring the allocation of financial resources to support and sustain a unified service delivery system for youth mental health. Such efforts include the development of common human resource policies and practices to support the formation of multi-disciplinary and integrated Child and Youth Teams. Similarly, the provision of integrated services also implies the adoption of common access processes across departmental systems, and the development of training for departmental stakeholders and service providers on how to facilitate access to services for youth and families where every door is the right door.

ISD Child and Youth Teams (CY Teams)

At a regional level, CY Teams represent an integration of services across government departments, providing inter-professional mental health services on a full-time basis within the school and community contexts. Evidence-informed practices and concepts from Assertive Community Treatment (ACT), Intensive Case Management (ICM) and Flexible Assertive Community Treatment (FACT) frameworks are used to guide and structure inter-professional intervention, and assessment and case management practices. CY Teams are comprised of a combination of professionals who have expertise in the delivery of assessment and intervention services in community, home and school settings. Members of CY Teams may include, but are not limited to:

- Psychologists
- Social workers
- Educational resource and guidance professionals
- Behaviour mentors
- Educational or community counsellors
- Healthcare professionals
- Occupational Therapists
- Nurses
- Child and youth care professionals or specialists
- Residents or interns in training from any of the preceding professional groups

Clinical Coordinators from Regional Health Authorities are assigned to each CY Team and play a key role in the coordination of the team's activities and the supervision of its members. The Department of Social Development provides a social worker as a sitting member of each CY Team. This includes attending weekly meetings, participation in collaborative case planning, and the development of case management responses that are youth focused and family centered. The Department of Justice and Public Safety provides the resources necessary to support and liaise with CY Teams when youth are in conflict with the law.

Within each region, CY Teams seek to develop collaborative working relationships, integrated practices and service linkages with other specialized departmental and community agencies that provide essential supports to meet the needs of youth and their families. CY Team intervention services include short-term and time-limited responses (e.g., supportive counselling, treatment, crisis response and clinical follow-up), as well as service responses that are longer in duration and more intensive (targeted treatment and multi-disciplinary approaches) to address more complex needs. CY Teams have the capacity to increase and decrease service intensity and to access resources as required, ensuring greater flexibility in supporting the continued and successful functioning of youth in the school, home and community contexts.

CY Team assessment services refer to any informal or structured data collection efforts undertaken to assist in the development of appropriate intervention plans and responses. Assessment activities may include the completion of file reviews, the execution of structured interviews and observational approaches, the administration of standardized measures, and the application of multidisciplinary evaluation methods. CY Teams have the capacity to adjust the scope and intensity of assessment based on the needs of the youth and the information required to structure intervention planning activities. Figure 1 provides a schematic of CY Teams and their functional linkages with points of access, youth-focused settings, partnership services and more intensive program supports. This schematic illustrates the capacity of CY Teams to activate step-up or step-down intensity levels to address the varying levels of need of youth and their families.

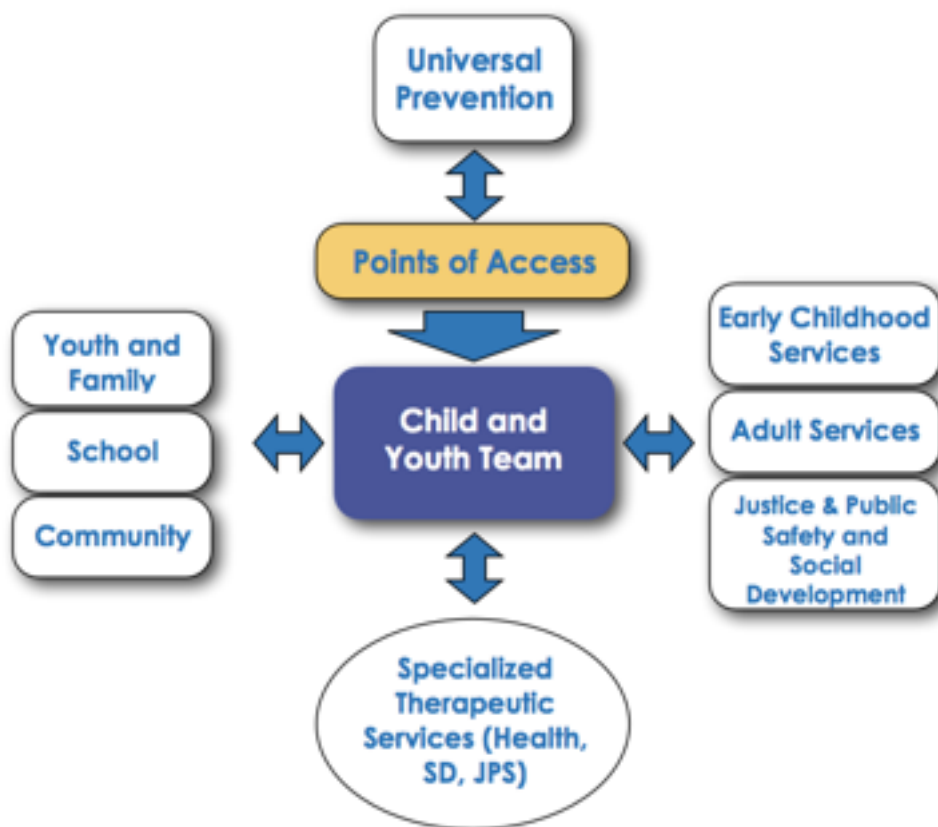


Figure 1: ISD Service Provision

School and Community Contexts

Each CY Team is assigned to provide services to a cluster of schools and communities within a given region. School clusters include elementary, middle and high school levels. Partners in each region determine the appropriate number of CY Teams, as well as the resources required for each team. CY Teams work closely with schools and serve as members of school-based student services teams where they have opportunities to consult, collaborate on interventions or provide access to more intensive mental health supports. The ISD Framework is consistent with tiered intervention models such as Response to Intervention (RTI) and Positive Behaviour Intervention Supports (PBIS), tailoring service supports to individual levels of need.

CY Teams provide a full range of services within the school setting, as well as within the community context, especially for youth who may not formally be engaged with educational services. Interventions in the community are provided through outbound services that reach youth and families in their natural social settings. The location of service delivery is flexible, reflecting the preferences of youth and families. In instances where children and youth may demonstrate complex needs requiring more intensive interventions, CY Team members collaborate with other regional and community resources to ensure that a common integrated work plan (the Common Plan) is developed to maximize all possible regional resources to support the child/youth and family. In certain cases, the CY Team will collaborate with other provincial services to ensure access to appropriate out-of-home and specialized supports with emphasis placed on transition planning aimed at the engagement of less intensive and/or intrusive services at the earliest and most appropriate time.

Accessing CY Team services is facilitated through school-based educational support teams, community-based mental health services, and primary healthcare professionals. Service providers within the community play an important role in connecting youth and families with services (*every door the right door*).

Integrated Governance and Regional Capacity

At the provincial level, oversight of the ISD Framework is provided by the ISD Sponsors Committee composed of Assistant Deputy Ministers and senior leadership from each Health Authority. Reporting to this senior governance group is the Provincial Directors Committee (PDC), representing the Ministries of Education and Early Childhood Development, Health, Social Development, and Justice and Public Safety. The PDC works in collaboration with the Provincial ISD team to monitor the ongoing regional operations of the ISD Framework and to address challenges related to departmental mandates, scope of service, and policies or practices that may emerge in the provision of mental health supports. The ISD governance model also incorporates the ability for decision making to be undertaken at the regional level,

and recognizes the capacity of ISD regions to deliver and refine services that reflect the strengths of communities, schools and families. The ISD Framework encourages integrated regional ownership and leadership among ISD departmental partners in collaboration with community-based agencies. Regional Operational and Directors Committees serve as a point of accountability and oversight for ensuring the delivery of responsive mental health services within an interconnected continuum of support. The close working relationships of these collaborative and integrative teams facilitate ongoing communication, a continuous flow of feedback and the application of shared expertise to problem-solve gaps or challenges related to accessing or providing mental health services. Overall, increasing provincial and regional collaboration among departmental and community ISD stakeholders reduces duplication of effort, makes more efficient use of limited resources and more effectively meets the complex mental health needs of youth and their families.

ISD Governance Structure

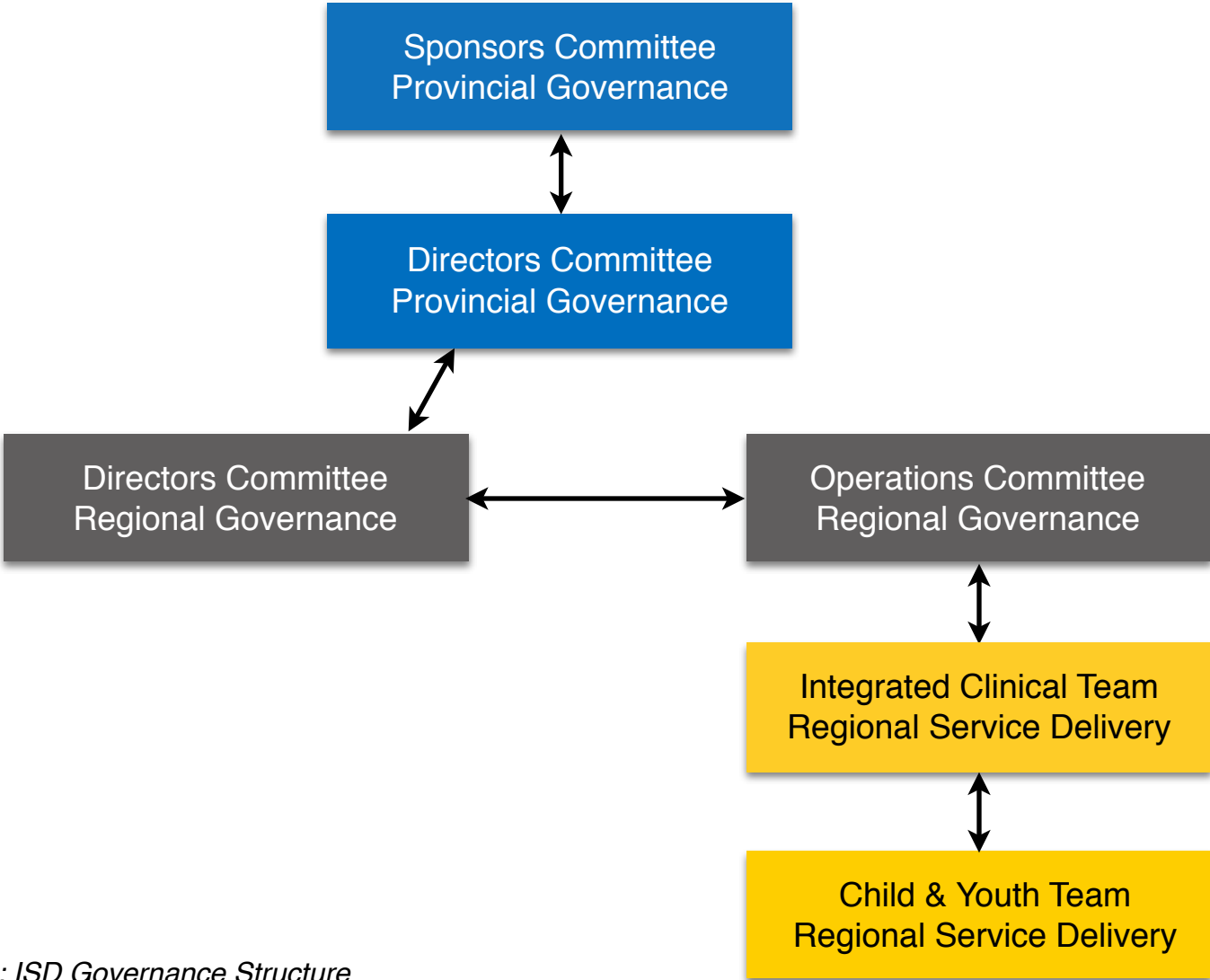


Figure 2: ISD Governance Structure

As indicated in Figure 2, ISD’s governance structure is comprised of provincial and regional interdepartmental committees from the following partner agencies:

- Education and Early Childhood Development
- Health
- Social Development
- Justice and Public Safety
- Regional Health Authorities
- School Districts

The Departmental Government Level

ISD’s governance structure is comprised of provincial and regional interdepartmental committees from the following partner agencies:

- ❖ ISD Sponsors Committee
- ❖ Provincial Directors Committee (PDC)

These committees ensure alignment of departmental mandates and policies, monitor the operational performance and resource allocations of the ISD framework, and refine ISD operational processes to reflect resolution of emerging fiscal, operational and departmental challenges.

Regional Governance and Leadership

The ISD framework ensures integrated ownership and leadership between ISD partners and community-based agencies in order to allow for a continuous flow of feedback, communication and sharing of expertise. The key component of the regional leadership is the Regional Directors Committee (RDC), which involves the membership of at least one representative from each of the partners and may also include other agencies and primary agents for access to services (e.g., RCMP liaison).

Program Delivery Level: Operations and Services

This level of oversight ensures the consistent and effective operation of the ISD framework. This includes the provision of services at the appropriate level of intensity, as well as the integration of departmental and community resources to address service gaps and to meet the comprehensive needs of children and youth with emotional and behavioural concerns.

The key components at the Program Delivery Level are:

- ISD Regional Operations Committee
- Integrated Clinical Team
- Child and Youth (CY) Teams

Decision making and issue resolution processes

- Any issues or requests for support that need to be brought to the attention of partners are brought forward by the ISD Regional Directors Committee Chair to the Provincial Directors Committee, with solutions and decisions communicated back to the RDC through the Chair.
- Regional strategies ensure that all partners are aware of the issue resolution process.

Accountability

The ISD Regional Directors and Operations Committees are accountable to their respective department/RHA/District, and to the ISD Sponsors Committee. CY team members work under the supervision of their respective RHA. The RHAs have operational and clinical oversight and provide direction to CY teams in accordance with the terms of a service agreement signed by all involved parties.

Information Sharing and Common Case Plans

The alignment of policies related to privacy and information sharing was crucial for facilitating clinical and case planning exchanges among members of ISD Child and Youth Teams. Changes in provincial legislation supported information sharing within the boundaries of the ISD Framework to assist in the determination of appropriate services and supports for youth and their families. Inter-professional dialogue and exchanges contributed to the identification of specific service and treatment options tailored to the needs of youth and families, as well as the determination of effective and strength-focused approaches for engaging and empowering them in the recovery process.

In addition to effective information sharing practices, the introduction of the Common Plan contributed to enhanced coordination and continuity of ISD services and supports. The Common Plan reflects the collaboration of youth and family members with CY Team members, the process of cooperation among all ISD partners, and the provision of a unified case plan that determines the most effective and appropriate service responses.

In the context of integrated service delivery/ISD, the Common Plan refers to a process of cooperation between all service providers for a child, youth, and/or his or her family. ISD is designed to mobilize all the skills and competencies required to ensure a collaborative and cooperative assessment of strengths, needs, and risks to be addressed. Efforts are focused on agreeing on priorities that must be addressed in order to meet needs and on the degree of services to be provided, in accordance with the mandates and responsibilities of each organisation concerned.

Operational Monitoring and Evaluation

The rollout of the ISD demonstration sites in the Acadian Peninsula/Ainwick region and Charlotte County included the development of operational monitoring measures and targeted evaluation activities to gain insight into the process of implementation and outcomes associated with the ISD Framework. Such efforts were critical for assessing the move from a theoretical model to real-life application of integrative service delivery processes, services and supports for youth with mental health concerns. The section entitled Evidence of Transformation provides selected outcomes from ISD evaluation documents, and underscores the importance of continued system monitoring and evaluation in the expansion of the ISD Framework across the Province of New Brunswick.

Network of Excellence

Overview of the New Brunswick Network of Excellence

The Network of Excellence (NOE) continuum of services and supports is designed to reach people in their own environments – at home, in schools and in the community – and seeks to strengthen the natural informal supports found within these settings. Intervention services are provided to youth and their families in their local community and regional contexts. When more intensive services are required, specialized services are accessed and connected within Common Plan strategies that ensure continuity of treatment support and service provision.

The NOE is committed to adjusting the level of service intensity and resources offered to effectively match the needs of youth and their families, and to support and sustain adaptive functioning in the home, school and community. This includes having the capacity and flexibility to increase service contacts with youth and to access additional supports when individual needs warrant more intensive intervention responses. Service delivery approaches foster youth and family self-determination and seek to decrease the level of service intensity at the earliest possible time appropriate to assessed needs.

The NOE embraces a recovery-oriented paradigm, emphasizing the participation of youth and family members in all aspects of the services they access to support the recovery process. Empowerment, choice and responsibility are promoted within the delivery of person-centered and autonomy-supported care approaches. From a recovery perspective, a continuum of interconnected services and supports should be flexible, collaborative and inclusive with youth and their families being at the center.¹⁸

Within a recovery service paradigm, service providers, clinicians and community stakeholders act as partners or coaches alongside youth and their families on their recovery journey. As collaborators, they engage youth and families in the recovery journey; share options and respect individual recovery choices; provide direct support to youth and families throughout recovery; and help them access the right supports within their local regions.¹⁹ Figure 2 presents an overview of New Brunswick’s NOE and its associated components, including its linkages to prevention-oriented strategies, the ISD Framework, community-based treatment programs and supports, and provincial tertiary-level treatment programs.

Network of Excellence

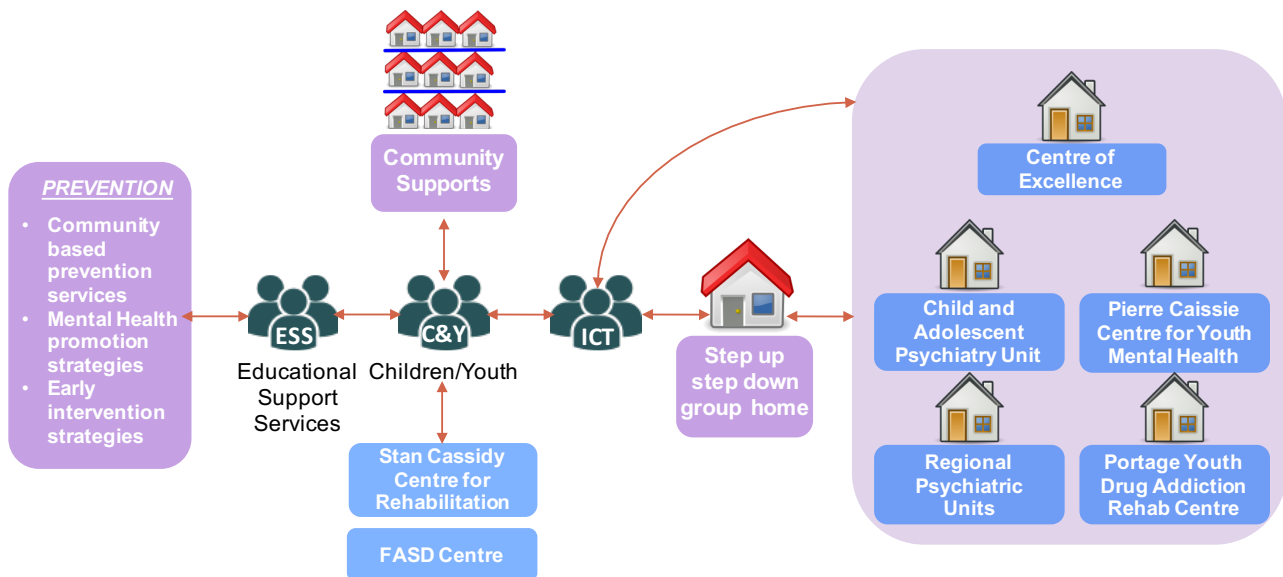


Figure 3: NB Network of Excellence Schematic *

*The following describes the components within the NOE Schematic.

ESS	Refers to student support services, which are organized on school-level Education Support Services Teams (ESSTs)
C&Y	Refers to interdisciplinary Child and Youth teams serving youth with mental health concerns in their school or community settings
ICT	Refers to Integrated Clinical Teams that serve in each of New Brunswick's health zones. These teams review all files from CY Teams where the recommendation is to increase the intensity of clinical services
Stan Cassidy	Refers to the Stan Cassidy Centre for Rehabilitation, part of the Horizon Health Network of New Brunswick
FASD Centre	Refers to the NB Fetal Alcohol Spectrum Disorder Centre of Excellence
Centre of Excellence	Refers to the New Brunswick Centre of Excellence, a planned 15-bed residential treatment centre for youth with complex needs
CAPU	Refers to the Child and Adolescent Psychiatric Unit in Moncton, NB
Pierre Caissie	Refers to the Pierre Caissie Centre's Youth Treatment Program in Moncton, NB
Portage	Refers to the Portage Atlantic Youth Drug Addiction Rehabilitation Centre

Changing the Culture of Mental Health Care

A foundational principle of the Network of Excellence is its commitment to shifting from a “medical model” to a person-centred, collaborative approach to care. This change in culture places emphasis on the involvement of families in assessment processes and throughout the wellness journey, with *the relationship* as a foundational piece of the intervention story. At the community level, the Network of Excellence is committed to ensuring that children and youth will rarely have to leave their communities in order to receive mental health/addiction services.

Moving to a collaborative approach has not only affected the work being done at the field services level, but has also had a profound affect on the conversations being held at the provincial partner level. The adoption of a client-centred approach led to the capacity for both

government and non-government service providers to open discussions and share information that challenged the status quo regarding youth mental health services. As silos disappear, youth and families are enabled and empowered to engage multiple services and supports without the need for retelling their stories, undergoing multiple assessment and intake processes, or struggling to understand how to navigate a disconnected system of provincial services related to mental health.

This cultural shift has involved the collaboration and merging of systems of support that cross the spectrum from clinicians, educators and field service workers to those in positions to impact policy and standards of practice at a provincial level. With families no longer forced to engage multiple, disconnected systems in order to meet the mental health needs of their children, the resulting *interconnected continuum of care* has created an “every door is the right door” approach to accessing needed supports. Regional decision-making and funding capacity has been enhanced to provide the appropriate level of service at a much earlier point of intervention, with the system flexing to meet the needs of families.

Trauma-Responsive Approach

The Network of Excellence involves the preparation of all youth mental health clinicians, including those serving on ISD Child and Youth teams within school settings, in trauma-responsive approaches to care. Not only are clinicians receiving training on trauma-informed practice, but the provincial approach to out-of-home care is also focusing on trauma response throughout New Brunswick’s child welfare system. In its early stages, this shift impacts out-of-home care services that formally exist within the continuum of services, including the development of specialized foster homes, community-based step up/down treatment centres, and youth mental health and addiction tertiary services.

Underlying Assumptions of the Trauma Model	
Traditional Model	Trauma Model
Priority on control.	Priority on collaboration and power of relationships.
Challenging behaviours viewed as needing to be changed.	Challenging behaviours viewed as adaptive; existing for a reason.
Priority placed on stopping negative behaviours.	Priority placed on building emotional regulation skills.
Clinician/service provider as authority and expert.	Clinician/service provider as collaborator.

Figure 4: Trauma Model, NB Department of Social Development

Developing and Extending the Capacity of the NB Network of Excellence

The ongoing development and expanding capacity of the NOE has contributed to the formation of key working groups, initiatives, program supports and treatment options that are critical for strengthening an interconnected continuum of services and supports, and for promoting recovery-oriented service approaches and practices. The following provides an overview of recent developments within the NOE.

Service Design Implementation Committee

The mandate of the Service Design Implementation (SDI) Committee is to consolidate and align service delivery within the Network of Excellence to ensure an integrated, collaborative, strength-based, trauma-responsive approach across the continuum of care for youth with mental health/addiction and behavioural/ emotional needs. All recommendations coming from this Committee are vetted through the *Service Delivery Guidance Teams*.

The Service Delivery Guidance Teams provide information and guidance to assist in the planning of the delivery of child and youth mental health services throughout New Brunswick. Each Guidance Team represents the interests of respective stakeholders, including youth, families, and First Nations communities. The Guidance Teams share opinions and perspectives to offer collective guidance on recommendations provided by the Service Delivery Implementation Team.

NB Youth Engagement Initiative

The intent of the NB Youth Engagement Initiative is to promote the resiliency and psychological wellness of youth through enhancing adult and youth connectedness, drawing on the collective strengths of these relationships, and providing youth with leadership opportunities in the community. The New Brunswick Department of Health's Addiction and Mental Health Services encourages the meaningful engagement of youth in community-based activities that contribute to the development of protective factors. The goals of the NB Youth Engagement Initiative are primarily to:

- Increase recognition of youth as valued partners in promoting positive change
- Foster connectedness among youth, their families and the wider community
- Encourage the participation of youth as leaders in setting directions for positive change

Strongest Families

The Strongest Families Institute is a not-for-profit organisation that provides community-based mental health and wellness services to children, youth and families. As part of the provincial Network of Excellence, this organisation expands the reach of government services through the provision of training and coaching programs for building awareness and skills for coping and thriving among New Brunswick families. Programs and training modules were developed by the Centre for Research in Family Health at the IWK Health Centre in Halifax, Nova Scotia. Research and program evaluation point to the efficacy of program components, and positive outcomes for children, youth and families.²³

ACCESS NB

As part of a national initiative funded by the Graham Boeckh Foundation and the Canadian Institute for Health Research, ACCESS NB is one of twelve Canadian demonstration projects that aim to transform youth mental health services across the country over a span of five years. ACCESS NB's transformation plan consists of four key elements:

- Developing safe spaces for youth with mental health issues to empower their voice and provide improved access to care
- Providing mental health training for all sectors of society to better identify and support youth with mental health needs
- Knowledge sharing both within the province and throughout the broader national network to ensure that New Brunswick youth benefit from the best clinical care practices
- Evaluating the results of the changes to youth mental healthcare²⁴

Centre of Excellence

The NB Centre of Excellence is a planned 15-bed residential treatment centre for youth with complex needs to be housed in the northern region of the province. While the centre will have a residential treatment capacity, clinical staff will also collaborate with other youth mental health services and programs throughout the province, increasing regional capacity to service the needs of youth within their own communities.

“The new provincial treatment centre will be an integral component of a network of excellence which will provide a continuum of support services ensuring comprehensive planning and delivery of services for children and youth affected by mental health in New Brunswick”.²⁵

It is envisioned that the Centre of Excellence will provide youth with complex needs and their families with timely and intensive tertiary-level services, under the guiding principles of recovery, trauma-informed and strength-based treatment approaches. In all cases, the goal of treatment will be to return youth to communities with the supports and skills needed to re-integrate into safe and healthy environments.

Part 4: Living Change, Transition and Challenge

The initial years of transforming youth mental health service delivery rendered new ways of providing service, and new service experiences for service providers, youth and families. During this time of change, significant transitions were experienced and challenges emerged that impacted and shaped regional approaches to youth mental health. A summary of key points of transition and challenge follows.

Shifting Service Paradigms

As integrated departmental approaches and inter-professional team formats evolved, the need for fundamental shifts in philosophy and orientation were required. This shift required leaders at all levels not only to reflect upon individual mandates or siloed programs, but also to re-conceptualize their service orientation to embrace a unified purpose and direction for youth mental health. This shift in paradigm involved the embedding of new beliefs and actions that entailed:

- Moving from siloed to team formats
- Embracing a child- and youth-centered orientation in place of existing system-centric decision-making approaches
- Refocusing on youth strengths in lieu of a sole focus on deficits or problems
- Taking ownership of common case plans as opposed to deferring service responsibilities because of existing mandates or scope of services

Re-profiling Departmental Clinical Positions on Integrated Child and Youth Teams

Mental health and addictions clinical positions from the Regional Health Authorities, student service personnel positions from schools and districts, and social worker positions from Social Development were re-profiled within a single team design model, resulting in the establishment of Child and Youth (CY) Teams. This multifaceted reorganisation required navigating collective agreements, working through professional association standards of practice related to ethics and scope of service, and designing an inter-professional framework to encourage the development and effective functioning of integrated CY Teams.

Leaving comfortable contexts of service characterised by siloed but autonomous practices was challenging for many service providers. A few professionals made the decision to exit the service system; however, the majority of early adopters to the inter-professional team format embraced the benefits of mutual support, shared expertise, collective ownership of cases, and the capacity to increase and decrease intensity of service without the need to refer youth to other services outside the system. Inter-professional training for the newly formed CY Teams was a critical component in creating readiness for professional change and in the realisation of positive team development and cohesion.

Coping with the Limitations of Existing Information Systems

As CY Teams brought together clinicians from multiple departments, the move to a single case plan for youth was essential for reducing the duplication of services, and for ensuring that services were effectively targeting the needs of youth. A key challenge that emerged in this move toward a common plan for youth was the inability of information systems from departments to connect with one another, and the inability of the system to provide common access to inter-departmental team members. As members were given access to new departmental information, they often lost access to their former systems. As a stop-gap measure during the development of a more inclusive information management system, the use of a paper-based case management system was developed. This system limited the accessibility of file information when CY Team members were working off-site to provide services in community settings. The upside of this limitation was the opportunity for team members to contribute to the design of new integrated forms for daily case plan use. Many of these practices were eventually incorporated into plans and actions for a common digital information system for integrated child and youth teams.

Merging Caseloads, Wait Lists and Access Points

The newly formed CY Teams were also tasked with the challenge of merging caseloads, reviewing wait list referrals, and determining common access points for youth and families. These efforts initially increased individual clinical workloads over several months, and involved balancing existing client needs as the move was made to the new team format and shared case management approach. The process of merging caseloads provided a unique opportunity to create single case plan files for youth and families who had been serviced previously by multiple service providers, subsequently reducing duplication and overlapping of services. The review of wait lists brought new needs to the forefront, and led to the elimination of wait list referrals that were inactive or that no longer required services.

Moving from Offices to Schools and Community Sites

Former departmental systems often involved the displacement of youth and families from their home or school contexts in order to attend counselling or case planning meetings in

offices and departmental buildings. In contrast, the newly formed CY Teams were outbound, meeting youth in school or familiar community locations. In fact, the majority of CY Team offices were housed in schools. For members of the CY Teams, especially those from Mental Health and Social Development, delivering services in the settings where youth were located marked a definitive shift in practice.

Locating offices and redesigning team work spaces in school and community settings involved the commitment of additional financial expenditures, the redesign of spaces to meet code requirements, and the evaluation of team spaces to ensure that they were both conducive for team collaboration and accessible for youth and families within the school and community. Positive outcomes associated with this transition in the location and delivery of services included reductions in attrition rates of youth appointments, increases in the number of youth being seen, and greater flexibility in service approaches to connect and reach youth and families at earlier points.

Collaborating across Educational, Health and Language Boundaries

Within departmental systems, different service boundaries existed among health authorities and school districts, including those related to the language of service provision activities. Given that CY Teams were organised to follow youth based on their local school regions, youth services and program supports from the health region, as well as those from other departments such as Social Development and Justice and Public Safety were delivered according to their own regional boundaries. Within the formation of the new integrated teams, regional consultations and the development of integrated governance approaches for youth mental health were imperative. Regional governance committees emerged with the capacity to undertake changes in service delivery practices on the ground, creating a pathway for more collaborative and integrative departmental practices in youth mental health.

Ensuring Voice and Choice for Youth and Families

Although significant changes in service delivery system approaches were undertaken during the initial integration of departmental services at the regional level, the need for youth, family and community engagement emerged as a critical area for development in ensuring that services were person centered, empowering and transformative. The creation of standards of practice for CY Teams underscored key assumptions and processes for ensuring engagement and collaboration with youth, families and communities. The Network of Excellence also introduced key program components and innovations that have contributed to ensuring the power of voice and choice among youth and family members within the process of recovery, including the creation of the provincial First Nations Guidance Team, the Youth Guidance Team, and the Family Guidance Team.

Part 5: Evidence of Transformation

In 2010, the initial demonstration sites for transforming youth mental health services were launched in the Acadian Peninsula and Charlotte County regions of New Brunswick. In September 2013, using an evaluation framework developed by the Health and Education Research Group of the University of New Brunswick,²⁶ the Centre de Recherche et de Développement en Éducation (Université de Moncton) released its evaluation report for the two demonstration sites.²⁷ Key findings are highlighted below.

Impact on the Positive Development and Mental Health Functioning of Children and Youth

- Youth who received services from CY Teams experienced decreased internalizing and externalizing concerns as measured by youth self-report and clinical ratings on the Achenbach scales.
- Youth who received services from CY Teams experienced increased adaptation within school routines and relationships as rated by teachers on the Achenbach scales.
- High levels of satisfaction were reported by parents whose children received services from CY Teams.

Increases in Access to Services

- National statistics demonstrate that approximately 20% of Canadian youth are affected by mental health concerns; however, only one out of every five youth (4%) who need help actually receive it. In the demonstration sites, 12% of total youth received treatment in Charlotte County and 8% in the Acadian Peninsula.
- The number of youth receiving mental health services within the demonstration sites doubled following the introduction of integrated service delivery practices.

Decreased Wait Times for Youth Mental Health and Addictions Services

- The number of youth placed on waiting lists for more intensive mental health and addictions services was reduced by 89% in the Acadian Peninsula, and by 100% in Charlotte County.
- The number of youth awaiting psycho-educational assessment was reduced by 66% in the Acadian Peninsula, and 32% in Charlotte County.

Youth- and Family-centered Focus

- Parents interviewed within the demonstration sites reported feeling supported and being part of intervention activities with their children.
- Based on daily operational reporting, over 80% of CY Team activities involved client-related sessions and collaborative service provision activities with youth and/or their families.
- Overall, regional operational outcomes suggested enhanced service efficiencies related to inter-professional team collaboration and client-centered methods.

The Provision of Timely and Coordinated Services

- Operational data from the demonstration regions indicated that youth were being seen at a much earlier point than prior to integration as a result of services being mobilized at the elementary and middle school levels.
- Time periods for accessing services were shorter given the outbound nature and location of CY Team services in school and community settings.
- Linkages between CY Teams and school-based Student Service Teams provided the potential for timely clinical consultation and the increased use of targeted and preventative interventions, averting the escalation of emotional or behavioural problems.
- During regional interviews, multiple stakeholders reported that the integration of services had effectively reduced duplication and redundancies among departments, and contributed to greater coherence in services delivered to youth and families.

Enhanced Regional Service Collaboration and Integration

- Both within and across regionally delivered departmental services (Social Development, Mental Health and Addictions, Justice and Public Safety and Education), there has been evidence of greater cohesion, flexibility and determination to work together in a unified effort to reach, engage and provide support to youth and families experiencing mental health concerns.
- Within integrated regional governance committees and CY Teams, strong professional satisfaction and enhanced confidence to promote transformative change in youth mental health have been reported.
- Enhanced knowledge and understanding of professional roles and areas of expertise among departmental stakeholders and CY Teams has also been documented.
- Enhanced communication among departmental stakeholders and CY Team members has contributed to the development of shared understandings and expanded perspectives related to youth and family needs and implications for service provision.

Information Sharing Policy Developments

In 2011, the Department of Education and Early Childhood Development (on behalf of all departments serving children and youth) requested a legal opinion from the Department of Justice to clarify the capacity for the sharing of information among professionals serving full-time as CY Team members and reporting to the Regional Health Authority. It was determined that an Omnibus Bill be submitted for approval to permit public bodies to share required information to determine eligibility for an Integrated Service Delivery program or activity. New provincial legislation was passed that allowed departments and agencies to first share necessary information, and then approach the family/child for consent to participate. This legislation facilitated the delivery of services at the school or community level at the appropriate level of intensity, and reduced the need for families and youth to navigate multiple systems and retell their stories each time a new service or support was accessed.

Provincial Crime Reduction Strategy

The integration of child and youth mental health services plays an integral role in the Department of Justice and Public Safety's Crime Reduction Strategy. The intent of this strategy is to divert youth who come in conflict with the law from being adjudicated through legal proceedings. The inclusion of integrated services and common plans in this departmental strategy has reduced the number of youth in custodial settings, and has facilitated access to needed mental health services and supports.

Expansion and Scaling Up

In September 2016, the demonstration sites engaging in transformative change for youth mental health were expanded to include the Miramichi, Bathurst, Campbellton and Saint John regions. This expansion represented approximately 44% of all provincial school regions being part of interdepartmental service integration. Preliminary data for the 2016 expansion sites indicate that in the first six months service access to youth had increased by 52% in comparison to the same time period the previous year for the same regions. Of youth accessing services in these regions, 58% were younger than those accessing mental health in other provincial regions where there was no service integration. The 9-11 age group realized the largest increase between 2016 and 2017.

Parent story, after integration of services in New Brunswick

“We’ve had long-term concerns about our son’s mental health. He’s been missing a lot of time at school and we were concerned that he may be falling in with the wrong crowd or even experimenting with drugs. We shared our concerns with a close friend who’s a teacher at the school. We were so surprised when she told us that she knew how we could get some support. Through the Student Services team at the school, we learned about ISD. Almost immediately, we had someone from the Child and Youth team reaching out to our son and supporting our family. We’ve been trying to get support for our son since he was in elementary school. This is really the first time that we feel there’s some hope. People seem to be working together to help him stay in school and to understand his problems. Even our communication at home is better. I guess we’re feeling hopeful!”



Part 6: Lessons Learned

Throughout the provincial rollout of integrated mental health services for children and youth, New Brunswick has gathered information related to lessons learned so that each expansion region might benefit from the experiences of others. The following sections highlight key insights resulting from implementation processes and practices. It is intended that outlining lessons learned in the New Brunswick context might benefit other jurisdictions interested in moving toward more integrated child and youth mental health services and supports.

Preparing for System Change

Taking time to prepare the demonstration regions for system change was identified as critical for supporting a collective and unified transition to new ways of working together in youth mental health. Regional meetings and sustained dialogue were essential for creating a shared vision for youth- and family-focused services and for clarifying common directions and interdepartmental processes for rolling out integrative team approaches. Departmental commitment and ownership for system change increased as stakeholders aligned their efforts, taking collective actions to transform services in youth mental health.

Building Regional Governance

The rollout of the ISD demonstration sites necessitated the building of regional governance structures to support the effective implementation of the integrated CY Teams and the alignment of departmental services within the ISD Framework. Two interdepartmental governance committees were formed: the Operational and Directors' Committees. These committees ensured a common vision for transformative change in youth mental health across departments, as well as the creation and refinement of service delivery processes essential to the creation of an interconnected continuum of support for youth and families.

Ensuring Consistent and Clear Communication

Across departments, messaging became imperative for moving forward collaboratively at both the regional and provincial levels. When messaging was consistent and clear, there was common understanding among stakeholders of shared goals and required actions for rolling out and sustaining integrated service delivery practices within demonstration site regions. In contrast, when there were perceived pauses in expanding ISD beyond the demonstration sites, feelings of uncertainty emerged about the future of ISD when communication was not immediate about current concerns or decisions. Some stakeholders have asserted the importance of appointing to the provincial ISD team a dedicated professional responsible for messaging and regional communications.

Applying Team Development Training Formats

Six to eight training days were allotted for bringing together CY Teams to provide training in the ISD Framework and inter-professional team practices. These training events were comprised of targeted, time-limited presentations on ISD team roles and practices, followed by group processing activities. These activities facilitated team exchanges, provided clarification regarding areas of concern, engaged joint problem solving of emergent challenges, and promoted the identification of effective team processes. Over the course of these training events, team cohesion developed and team awareness of respective professional roles increased. In particular, recognition of team strengths and the richness of the teams' collective expertise was acknowledged and celebrated. A series of training eBooks was developed by the Health and Education Research Group at the University of New Brunswick in order to ensure consistent and ongoing training approaches, orientation and professional development for existing and new CY Team members.

Engaging Youth and Families

A foundational part of New Brunswick's plan for transforming youth mental health services was the meaningful engagement of youth and families as collaborators in the process of positive change. This remains an area for ongoing development. Stakeholders have asserted the importance of creating sustainable structures that ensure the authentic engagement of youth and families, and that ensure that their voices and needs are pivotal in shaping service provision approaches related to youth mental health. During the implementation phase, it was noted that while youth and families have increased options for exercising voice and choice in intervention planning, further opportunities for youth and family engagement should be explored.

As a response, the Network of Excellence is in the process of organising provincial structures to include a Youth Guidance Committee, a Family Guidance Committee, and a First Nations Guidance Committee. Once established, these committees will ensure that all youth mental health services are provided with the participation and oversight of youth and family stakeholders. Ongoing evaluation processes will involve the review of the efficacy of these provincial structures.

Engaging the Capacity of Early Adopters

The early adopters of transformative system change from the ISD demonstration regions became champions and advisors throughout the expansion to new regional sites. These individuals included members of the Child and Youth teams, school principals and educators, and regional and departmental leaders. These individuals shared with new regions their experiences of transformative change, and advised other regional and department stakeholders about the benefits of collaborative and integrative approaches. In addition, champions demonstrated how to adapt and introduce new processes for ensuring responsive team

responses in school and community settings, and shared stories of how system change has positively impacted the lives of youth and families. As stories and lessons learned were shared at regional orientation and training events, enhanced openness and clarity were evident among new demonstration regions, accompanied by increased optimism and hope related to making a positive difference in the lives of youth.

Moving Beyond Service Agreements

In the ISD demonstration sites, an immense amount of time and energy was dedicated to negotiating service agreements in order to facilitate the formation of regional integrated Child and Youth Teams. Although these efforts provide the basis for moving forward with the initial demonstration site applications, embedding integrated service delivery practices will need to consider more long-term solutions for sustaining team efforts. This will conceivably involve moving beyond service agreements to the permanent re-profiling of Child and Youth Team positions across provincial regions.

Aligning and Integrating Policies Related to Information Sharing

Transformation at the provincial policy level emerged as an urgent priority following the implementation of the initial ISD demonstration sites. New Brunswick's Privacy Legislation protects the confidentiality of Personal Health Information (PHI), and both privacy and right to information issues are overseen by a Provincial Privacy Commissioner. CY Teams were tasked with providing consultation, services and supports for youth and families who were, in some cases, already accessing supports from various departments or agencies.

With the implementation of the ISD Framework, it was necessary to undertake a Privacy Impact Assessment (PIA) to identify system-wide privacy risks. The PIA resulted in the adoption of Omnibus Bill 23 that "clarifies the parameters for the sharing of personal and personal health information," and ensures that "sharing is in the context of authorized integrated social programs, services and activities that benefit an individual".²⁹ Public employees working within the ISD Framework adhere to the amendments under Bill 23, sharing information across agencies and departments (limited to only what is necessary to perform duties) in order to develop a plan or intervention. Teams then work with the youth and family to gain consent to implement the plan.

Assessing Progress Toward Transformational Change

Initial evaluation activities and data collection processes were designed to:

- evaluate the fidelity of the ISD implementation to the ISD model, as outlined in the Indicators of Change framework in both demonstration sites;
- identify strengths and challenges linked to the implementation of ISD; and

- document results and changes linked to the implementation of ISD in terms of system integration, partnership building, inter-professional capacity, and service access and utilization.

Case study methodology was adopted to facilitate the investigation of emerging processes and approaches to the integration of services within the demonstration sites. Activities included the analysis of statistics related to utilization, wait lists and wait times, and data collected through the Child Behaviour Checklist completed for each youth at the point of intake. Qualitative methods included interviews, focus groups and site observations.³⁰

The ISD *Indicators of Change Instrument*³¹ was identified as a key tool for bringing together departmental stakeholders to reflect on integrative practices related to youth mental health services. Areas of review include indicators related to governance, service accessibility processes, service philosophy and orientation, CY Team functioning, and engagement and participation of youth, family and community members. By benchmarking current integrated service delivery practices on a regular basis, areas of accomplishment and areas for development emerge, providing the basis for discussing and developing plans for refining regional youth mental health practices over the long term.

Simplifying Referral Processes for Families

While access points for mental health services have been expanded to include referrals by school-based Student Services Teams and other community service providers, parents are still experiencing a degree of challenge in understanding referral processes and the scope of services provided through CY Teams. Referrals have been received through schools, the Mental Health and Addiction phone lines, medical practitioners, community psychologists, counsellors and youth-serving agencies. However, parents have reported that online information related to ISD lacks clarity, and does not provide a readily understood avenue for referral. Regions and CY Teams encourage the development of a more user-friendly website that provides parents, caregivers and youth themselves with a clear path to needed services, including regional contact numbers and links for requesting information or supports.

Change Management

The Province of New Brunswick has identified a need to undertake a change management process among government youth mental health stakeholders. A provincial committee has been established to identify the necessary change management sessions to assist practitioners in making this critical shift to a more collaborative and integrated system of care.

Part 7: Expanding Transformation in Youth Mental Health

The initial outcomes reported by the initial ISD demonstration sites and recent operational findings from the 2016 regional expansion provide evidence of enhanced system capacity to reach and provide targeted supports to a greater number of youth with emerging and existing mental health concerns in their school and community settings. In many instances, wait lists and wait times have been drastically reduced or eliminated altogether. The Network of Excellence is emerging as an overarching service framework for ensuring the creation of an interconnected continuum of support and services for youth and their families. A key thrust of the network is engaging youth, family and community voice and choice in helping to shape service delivery practices and the quality of service experience in youth mental health.

In September 2017, the ISD Framework and the Network of Excellence were expanded to cover all provincial jurisdictions, with person-centered services and supports related to youth mental health provided in both official languages throughout New Brunswick communities and schools. Currently, youth are served by 44 dedicated, inter-disciplinary Child and Youth Teams who deliver services in school, community or home settings, depending of the preferences of children, youth and their families.

As part of the provincial rollout, departmental and community stakeholders have identified the following key considerations for ensuring the ongoing and widespread transformation of youth mental health services.

Embedding of a Unified Vision for Youth Mental Health

The philosophy and assumptions underlying the ISD Framework and the Provincial Network of Excellence have reinforced perspectives related to strength-focused approaches, youth- and family-centered practices, positive mental health environments and positive youth development. These perspectives are closely associated with the recovery model, which places emphasis on the participation of youth and family members in all aspects of the services they access to support the recovery process. Empowerment, choice, and responsibility are promoted within therapeutic relationships and treatment programs with participants to ensure the delivery of person-centered and autonomy-supportive care approaches. From a recovery perspective, system services are designed to be flexible, collaborative and inclusive. As service delivery methods are transformed across the province, embracing and embedding recovery-oriented perspectives will strengthen and contribute to cohesion in collaborative and integrative practices in youth mental health.

Engagement with First Nations Communities

A formal process has been undertaken between ISD and New Brunswick's First Nations communities to begin the process of operationalizing and embedding integrative services for youth mental health. The goal of these consultations is not simply to overlay the ISD Framework upon existing service delivery systems within First Nations communities, but to enhance and expand the framework in ways that capture the essence of the indigenous paradigm and its pathways to wellbeing.

New Brunswick's First Nations communities vary in their delivery of educational services, with students from some regions attending Band Operated Schools from Kindergarten to Grade Eight, and students in other regions attending public schools at all grade levels. Currently, CY Team members collaborate with education teams in some Band Operated Schools, while in other regions linkages have not been formalized. It is envisioned that CY Team members might sit on all existing or newly formed Educational Support Services Teams in Band Operated Schools, and link with existing community resources including psychologists, social workers, addiction workers, Healing Teams and Circles of Care. Such collaboration would result in the adoption of practices and approaches based on indigenous paradigms that would benefit not only First Nations youth and families, but all New Brunswickers served by CY Teams.

Creation of a Formalized ISD Governance Structure at the Provincial Level

The establishment of a sustainable governance structure at the provincial level (e.g. Secretariat of Child and Youth Services) will be critical for sustaining the capacity of regional Integrated Service Delivery Programs, and for supporting the work of the broader Network of Excellence. Such a structure would include interdepartmental leadership with clear protocols for collaborating with regions and for monitoring service delivery processes associated with regional ISD services.

Refinement of a Single Information System for Youth Mental Health Services

It will be critical for all members of the Child and Youth Teams to have access to a common online information management system that will support integrative service delivery efforts, allow for service provision in diverse locations, and contribute to common case plan development and follow-up.

Implementation of a Service Monitoring and Feedback System for Youth Mental Health

The development of specific system mechanisms for monitoring the operational outputs and effectiveness of the ISD program and the provincial Network of Excellence will be an important consideration in assessing system efficiencies and impact. The development of

such system monitoring mechanisms should be guided by key performance or fidelity indicators that are evidence-based and foundational to supporting integrative service responses, and to the creation of interconnected continuums of support for youth and their families. Ideally, the implementation of such a service monitoring and feedback system would contribute to continuous service enhancements and innovations in regional youth mental health services and programs.

Continued Development of the Network of Excellence

The Network of Excellence is emerging as a unifying structure for all services and supports for youth and families experiencing mental health concerns. When brought together, such services form a continuum of support ranging from proactive and prevention-oriented programs to more intensive and longer-term services for youth with more complex concerns and needs. The Network of Excellence will promote the expansion of collaborative and integrative service efforts at regional and provincial levels with the aim of realizing a strengthened, seamless, interconnected continuum of support for youth and families. Specific advisory structures and engagement processes will be critical for ensuring that the voice and participation of youth and families will play an even greater role in shaping youth mental health service provision and service experience within the Network of Excellence.

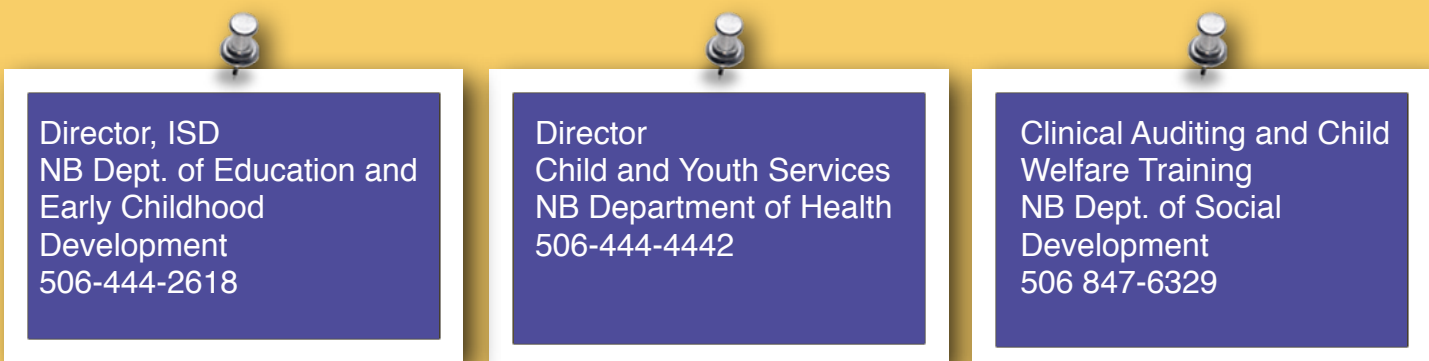
Promotion of Positive Mental Health Environments

Current literature underscores the importance of creating youth-centered environments that facilitate the fulfillment of the psychology wellness needs of all youth. Such positive mental health environments promote relationship practices that address the core psychological wellness needs of youth: relatedness (being welcomed, known and cared for); competency (recognizing and using strengths, building confidence); and autonomy support (having voice, choice and opportunities to be generous towards others). When these needs are addressed in the home, school and community settings, youth are more likely to thrive and flourish in their daily routines and relationships. Within several school districts involved with the ISD program, initiatives are in place to promote the creation of positive mental health environments that address the psychological wellness needs of all students, but also serve to bolster targeted mental health services for individual youth.

Ensuring Continuity of Service for Youth in Transition

It is critical that youth accessing services from ISD Child and Youth Teams or other programs within the Network of Excellence be provided with continuity of services as they transition to adulthood within their communities and local regions. Lessons learned from the transformation of youth mental health care are also contributing to new insights for enhancing services for adults within the province of New Brunswick.

This document provides a concise version of the transformation of youth mental health services in New Brunswick. The content of this story incorporates diverse perspectives from multiple stakeholders; however, it is hard to convey within a single document all the important insights and practices that contributed to positive change in youth mental health services. We encourage you to further explore transformative mental health services by contacting the individuals below.



Director, ISD
NB Dept. of Education and
Early Childhood
Development
506-444-2618

Director
Child and Youth Services
NB Department of Health
506-444-4442

Clinical Auditing and Child
Welfare Training
NB Dept. of Social
Development
506 847-6329

Dr. Bill Morrison
Co-Executive Director
Health and Education Research Group
Faculty of Education
University of New Brunswick
wmorriso@unb.ca

Dr. Patricia Peterson
Co-Executive Director
Health and Education Research Group
Faculty of Education
University of New Brunswick
PLP@unb.ca

Works Cited

1. Canadian Institutes for Health Research (CIHR). (2010). *Access and wait times in child and youth mental health: A background paper*. The Canadian Association of Paediatric Health Centres; The National Infant, Child, and Youth Mental Health Consortium Advisory; The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO.
2. Heathfield, L., & Clark, E. (2005). Shifting from categories to services: Comprehensive school-based mental health for children with emotional disturbance and social maladjustment. *Psychology in the Schools, 41*(8), 911-920.
3. Anderson-Butcher, D., & Ashton, D. (2004). Innovative models of collaboration to serve children, youths, families and communities. *Children and Schools, 26*(1), 39-53.
4. Richardson, L., McCauley, E., & Katon, W. (2008). Collaborative care for adolescent depression: a pilot study. *General Hospital Psychiatry, 31*(1), 36-54.
5. Fleury, M., & Mercier, C. (2002). Integrated local networks as a model for organizing mental health services. *Administration and Policy in Mental Health, 30*(1), 55-73.
6. Frankford, E. (2007). Changing service systems for high-risk youth using state-level strategies. *American Journal of Public Health, 97*(4), 594-599.
7. Boydell, K., Pong, R., Volpe, T., Tilleczeck, K., Wilson, E., & Lemieux, S. (2006). Family perspectives on pathways to mental health care for children and youth in rural communities. *National Rural Health Association, 22*(2), 182-188.
8. Barnett, D. (2012). A grounded theory for identifying students with emotional disturbance: Promising practices for assessment, intervention, and service delivery. *Contemporary School Psychology, 16*, 21-31
9. Heathfield, L., & Clark, E. (2005). Shifting from categories to services: Comprehensive school-based mental health for children with emotional disturbance and social maladjustment. *Psychology in the Schools, 41*(8), p. 914.
10. MacKay, A.W. (2006). *Connecting care and challenge: Tapping our human potential*. Province of New Brunswick.
11. Office of the New Brunswick Ombudsman and Child and Youth Advocate. (2008). *Connecting the dots: A report on the condition of youth-at-risk and youth with very complex needs in New Brunswick*. Province of New Brunswick.
12. Office of the New Brunswick Ombudsman and Child and Youth Advocate. (2008). *The Ashley Smith Report*. Province of New Brunswick.
13. McKee, M. (2009). *Together into the future: A transformed mental health system for New Brunswick*. Province of New Brunswick.

Works Cited

14. van Veldhuizen J.R. & Bahler, M. (2013). *Flexible Assertive Community Treatment: Vision, Model, Practice and Organization*. Groningen, The Netherlands.
15. Barrett, S., Eber, L. & Weist, M. (Eds.) (no date). *Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support*. Monograph of the Interconnected Systems Framework (ISF).
16. Province of New Brunswick. (2013). *Change vision: Helping people in their recovery journey*. Vitalité and Horizon Health Networks, NB, p. 9.
17. Province of New Brunswick. (2015). *Framework for the Delivery of Integrated Services for Children and Youth in New Brunswick*. NB Integrated Service Delivery.
18. Cunningham, R. (2012). Recovery in Scotland – Playing to strengths. *Drugs: Education, Prevention and Policy*, 19(4): 291–293.
19. Government of New Brunswick. (2013). *The Action Plan for Mental Health in New Brunswick 2011-18*. Province of New Brunswick.
20. Truth and Reconciliation Commission of Canada. (2015). *Calls to Action*. Retrieved on January 6, 2017 from http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf
21. Health Canada. (2015). *First Nations Mental Wellness Continuum Framework*. Retrieved on January 6, 2017 from http://nnapf.com/wp-content/uploads/2015/01/24-14-1273-FN-Mental-Wellness-Framework-EN05_low.pdf
22. Ibid. Pg. 9.
23. Strongest Families Institute website. Accessed in April 2017 at www.strongestfamilies.com.
24. Government of New Brunswick. (2015). *New Brunswick mental health network for youth funded*. Press Release of the Office of the Child and Youth Advocate, 23 January 2015.
25. Government of New Brunswick. (2015). *Provincial youth treatment centre to be built in Campbellton*. NB Government Press Release, 09 May 2015.
26. Morrison, W. & Peterson, P. (2013). *ISD Evaluation Framework*. Province of New Brunswick.

Works Cited

27. Centre de Recherche et de Développement en Éducation. (2013). *ISD implementation evaluation: Final report*. Université de Moncton.
28. Bourque, J. & Desjardin, P.-M. (2013). *Integrated Service Delivery Cost Analysis*. Centre de Recherche et de Développement en Éducation (CRDE), Université de Moncton.
29. Mignault, D. & Snow, K. (2016). *ISD and Privacy*. A presentation prepared by the Chief Privacy Officers of Vitalité and Horizon Health Regions, Province of New Brunswick.
30. Centre de Recherche et de Développement en Education. (2013). *ISD implementation evaluation: Final report*. Université de Moncton.
31. Morrison, W. & Peterson, P. (2013). *ISD Indicators of Change Framework*. Province of New Brunswick.