2007/2008 : Report 2

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The Child and Youth Mental Health Plan:

A Promising Start to Meeting an Urgent Need

Ministry of
Children and Family
Development

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The Child and Youth Mental Health Plan : a promising start to meeting an urgent need

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The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Province of British Columbia
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Victoria, British Columbia
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Dear Sir:

I have the honour to transmit herewith to the Legislative Assembly of British Columbia my 2007/2008 Report 2: The Child and Youth Mental Health Plan: A Promising Start to Meeting an Urgent Need.

Errol S. Price, CA
Acting Auditor General

Victoria, British Columbia
June 2007

copy: Mr. E. George MacMinn, Q.C.
Clerk of the Legislative Assembly

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Acting Auditor General's Comments

Errol S. Price, CA
Acting Auditor General

Families, communities and governments share responsibility for ensuring that children and youth have access to the resources that promote health, well-being and optimal human development. Despite considerable efforts, however, some children and youth develop serious mental health problems and may not always receive the services they need. Continuing impairments often lead to difficult, diminished lives on into adulthood.

Research suggests that 15% of children and youth (one in seven) in British Columbia have a mental disorder serious enough to cause them and their families significant distress. Such disorders can impair the development of these children and their ability to function at home, at school, and in the community.

In 1999, the Ministry of Children and Family Development, supported by the Ministry of Health Services, embarked on a children's mental health planning process. The aim was to take a closer look at the issues and to recommend how the system could be improved to better meet client needs. The ministries found that the child and youth mental health system in British Columbia had become a complex network of diverse services that were often poorly coordinated and insufficient to meet the needs of children, youth and their families. Furthermore, the ministries realized, too little attention had been paid to addressing their mental health and developmental needs earlier, before the emergence of a severe impairment that could disable them for life.

This planning process resulted in the province's first Child and Youth Mental Health Plan, published in February 2003, which set out to improve the mental health outcomes of children and youth.

We conducted this audit to assess the adequacy of the ministry's work to develop and implement the plan. Specifically, we sought answers to the following questions:

- Is the ministry's plan for improving the mental health outcomes of children and youth adequate?
- Is the ministry choosing appropriate key initiatives to implement the plan?
- Is the ministry adequately implementing its key initiatives?
- Is the ministry providing adequate accountability information about the plan's implementation?

Our audit was carried out from September through November 2006. Because implementation of the plan covers the five-year period from April 1, 2003, to March 31, 2008 (which means

it is still in progress), we focused on the processes the ministry has used to develop and implement the plan. We did not look at the achievement of the planned outcomes or whether the intended outcomes are the right ones. Those will have to be evaluated at a later date when the plan is fully implemented. The quantitative information we provide was drawn from various ministry sources. Although we checked the information for reasonableness, we did not audit it.

Our examination was performed in accordance with assurance standards established by the Canadian Institute of Chartered Accountants, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

Overall Conclusion

We concluded that the Child and Youth Mental Health Plan of the Ministry of Children and Family Development is an adequate plan for improving the mental health outcomes of children and youth, and that the ministry is satisfactorily managing the plan's implementation.

The plan was developed with extensive stakeholder consultations and was overseen and approved by a knowledgeable external advisory group. Although all parties know that significant work remains to be completed, the plan continues to have a high level of stakeholder support. The ministry has also chosen appropriate initiatives to achieve the plan's goals and is satisfactorily putting them into effect. One gap we noted is the ministry's lack of public reporting on the plan's implementation and a suitable framework for evaluating the extent to which mental health outcomes are being improved.

As we were completing our audit, the ministry was reorganizing its operations to better integrate its services. Many stakeholders told us they were concerned that the ministry's proposed changes in responsibilities and accountability relationships associated with the plan could undermine the gains achieved to date. (This reaction, we realize, stems from the historical challenges that the Child and Youth Mental Heath Program has faced establishing itself in a large ministry.) We understand these concerns, and urge the ministry, as it finalizes its organizational changes, to maintain adequate accountability mechanisms between the regions and the provincial office so that plan objectives remain a priority, at least during the

final year of implementation, and ensure that there continues to be strong leadership for child and youth mental health services. The ministry also needs to address stakeholder concerns about the changes taking place, and to begin formulating strategies that build on the gains made through the plan.

Key Findings and Recommendations

The ministry's Child and Youth Mental Health Plan is an adequate plan for improving the mental health outcomes of children and youth

The plan met our expectations reasonably well. It reflects the findings of an extensive stakeholder consultation process, and a knowledgeable external advisory group was established by government to oversee its development. Resource requirements to carry out the plan were satisfactorily considered and have been fully met to date. The plan is consistent with the strategic direction of both the government and the ministry and it continues to have the support of key stakeholders. Nevertheless, while many stakeholders see the plan as a "good start," they also acknowledge that much work remains to be completed. While the plan adequately describes the disorders treated under the program, we think that the ministry needs to reaffirm with clinical staff its policy on treating patients with both a mental disorder and a developmental or learning disorder.

We recommend that the ministry ensure that clinical staff clearly understand the ministry's policy on treating patients with both a mental disorder and a developmental or learning disorder to ensure a consistent approach across the province.

Many stakeholders are concerned that the ministry's reorganization could undermine the plan's accomplishments

The ministry is entering the final year of the plan's five-year implementation and has begun making organizational changes aimed at improving the integration of its services. The changes, however, are causing concern among stakeholders. Among their concerns are a reduced role for some staff who have been key in developing and implementing the plan, and alterations to the accountability structure that has thus far helped ensure that plan-related funding is used solely for the intended purposes.

The details of the changes had not been completely defined at the time we were completing our audit. Also not clear was whether the ministry is making plans to build on the accomplishments of the plan to date.

As the ministry finalizes its organizational changes, we recommend that it:

- **ensure that adequate accountability mechanisms continue to exist between the ministry's regional operations and the provincial office so that plan objectives remain a priority, at least during the final year of implementation;**
- **ensure that there continues to be strong ministry leadership for child and youth mental health services;**
- **address stakeholder concerns about the reorganization; and**
- **begin formulating new strategies that will build on the accomplishments achieved under the province's first Child and Youth Mental Health Plan.**

The ministry is adequately ensuring that its key initiatives are consistent with the plan goals and appropriately supported

The Child and Youth Mental Health Plan was developed to address several deficiencies in the mental health care system in the province. The ministry was aware of the need for:

- more timely and effective treatment and support services;
- programs to reduce the risk of, and prevent and mitigate the effects of, mental disorders;
- new efforts to improve the capacities of families and communities to prevent or overcome the harmful impact of mental disorders in children and youth; and
- better systems to coordinate services, monitor outcomes, and ensure public accountability for policies and programs.

The plan notes that coordinated approaches are required on all these levels. In response, the ministry has chosen a variety of initiatives to implement provincially and regionally. We found these initiatives to be consistent with the goals of the plan and appropriately supported by research, expert opinion, stakeholder consultation and/or value-for-money principles. That said, many groups (particularly physicians) have a key role in the mental health

system and the relationships are complex making it important for the ministry to have a clear plan to improve inter-sectoral collaboration.

We recommend that the ministry develop a clear strategy to bring about meaningful inter-sectoral collaboration, particularly with physicians.

The ministry is adequately planning and monitoring initiative implementation, but improvements can be made

The plan is being implemented in two phases. Phase 1 (from April 1, 2003, to March 31, 2004) focused primarily on improving performance in the system (e.g., using evidence-based treatments). Phase 2 (from April 1, 2005, to March 31, 2008) involves shifting the focus to strengthening and increasing the capacity of the children's mental health service system (e.g., increasing clinical staff) so that the gap between need and capacity will be substantially reduced.

The ministry has an approved charter that continues to guide the overall plan implementation, and it uses more detailed plans and monitoring processes to manage specific initiatives such as FRIENDS (a school-based anxiety prevention program) and a computerized clinical intake screening tool (known as BCFPI). Similarly, approved detailed plans and monitoring processes guide the work in each of the five regions of the province. Overall, stakeholders think that plan initiatives have been satisfactorily implemented. We agree with that assessment in general, but also see several opportunities for improvement.

To improve implementation of the initiatives, we recommend that the ministry:

- **ensure that all clinicians receive core, evidence-based practices training, that clinical supervisors consistently review staff application of the concepts, and that evidence-based practice parameters be integrated into services;**
- **develop school-based FRIENDS champions in under-represented regions, develop strategies to mitigate key risks and establish mechanisms to monitor penetration of the program throughout the province; and**
- **take steps to increase staff acceptance of the Brief Child and Family Phone Interview clinical intake screening tool.**

Acting Auditor General's Comments

The ministry has not provided adequate accountability information about the plan's implementation

Government is providing significant resources to the ministry to implement the plan and stakeholder expectations have been raised. It is therefore incumbent on the ministry to report to the Legislative Assembly and the public on the status of implementation progress to date and, ultimately, on the impacts the improvements are having on child and youth mental health outcomes.

We found, however, that the ministry has not yet produced a public report on the plan's implementation. The ministry prepared a summary report for Treasury Board in September 2006 to support its funding request for the final year of the plan, but that report was not made public. Also needed is an approved accountability framework for evaluating the extent to which mental health outcomes have improved as a result of the plan's implementation. The ministry is aware of this limitation and has begun discussing plans to evaluate outcomes once the plan is fully implemented.

To improve accountability for the Child and Youth Mental Health Plan, we recommend that the ministry:

- **report to the Legislative Assembly and the public on the plan's implementation progress; and**
- **develop an approved accountability framework capable of evaluating the plan's impact on patient outcomes.**

I wish to thank everyone who cooperated with my Office and assisted us in gathering the information for this audit. As well, I would like to acknowledge the hard work, professionalism and dedication of my staff in the production of this report.

Errol S. Price, CA
Acting Auditor General

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Child and Youth Mental Health in British Columbia

The first, most enduring responsibility of a society is to ensure the health and well-being of its children and youth. "Mental health" is how people think, feel and act as they face life's situations. It affects how people handle stress, relate to one another and make decisions. Mental health influences the way individuals look at themselves, their lives, and others in their lives and it is important at every stage of life.

Like adults, children and youth can develop any of a range of mental disorders. In this age group, these disorders are caused mostly by biological and environmental factors. Examples of the former are genetics, chemical imbalances in the body, and damage to the central nervous system. Examples of environmental causes include:

- exposure to environmental toxins;
- exposure to violence;
- stress related to chronic poverty, discrimination or other serious hardships; and
- anxiety related to the loss of important people through death, divorce, or broken relationships.

Exhibit 1 provides examples of mental disorders for which the Child and Youth Mental Health program provides services.

Exhibit 1

Examples of child and youth mental disorders

■ any anxiety disorder	■ conduct disorder
■ bipolar disorder	■ any depressive disorder
■ obsessive-compulsive disorder	■ pervasive development disorder
■ Tourette's disorder	■ schizophrenia
■ attention deficit/hyperactivity behaviour disorders	■ any eating disorder

Source: Ministry of Children and Family Development

Mental disorders in children and youth can lead to school failure, family conflicts, alcohol and drug abuse, violence, and even suicide. If left untreated, the disorders can be very costly to families, communities, and the health care system.

Background

In 1999, the Ministry of Children and Family Development set out to look more closely at children and youth with mental disorders and at how well the health care system was meeting their needs. Children are defined as those under 13 years of age; and youth, as those under 19 years of age.

Research suggests that mental disorders constitute the most important group of health problems that children and youth suffer —in fact, superseding all other health problems in terms of the numbers affected and the degree of impairment caused. A report prepared in 2002 by the Mental Health Evaluation and Community Consultation Unit at the University British Columbia suggests that one in seven (more than 140,000) children and youth in British Columbia has a mental disorder serious enough to cause significant distress and to impair their development and functioning at home, at school, and in the community.

Unfortunately, the research also suggests that all too often these children, youth and their families were not receiving the services they needed. Impairments often continued, leaving the afflicted with difficult, diminished lives and affecting their productivity and functioning in adulthood. A contributing reason for the unmet need was that child and youth mental health programs and services had evolved in British Columbia into a network of diverse services provided by a variety of practitioners working in community, hospital, and residential care settings. While efforts had been made over the years to improve services, serious weaknesses remained. For example, services were often found to be poorly coordinated and insufficient to meet the needs of children, youth and their families. Furthermore, too little attention had been paid to addressing the mental health and developmental needs of children and youth early on, before the emergence of severe impairments that could disable them for life.

British Columbia's First Child and Youth Mental Health Plan

To help address the above concerns, the Ministry of Children and Family Development, supported by the Ministry of Health Services, developed British Columbia's first Child and Youth Mental Health Plan. Published in February 2003, the plan states that "to better meet the mental health needs of children and youth, new approaches and additional resources are urgently needed." The plan also notes

that the challenge is too large to be met solely by increased clinical services. Rather, a coordinated approach is required on several different levels. These, according to the plan, include:

- more timely and effective treatment and support services;
- programs to reduce the risk of, and prevent and mitigate the effects of, mental disorders;
- new efforts to improve the capacities of families and communities to prevent or overcome the harmful impact of mental disorders in children and youth; and
- better systems to coordinate services, monitor outcomes, and ensure public accountability for policies and programs.

The plan calls for a staged approach over five years (April 1, 2003, to March 31, 2008) to improve child and youth mental health outcomes. The plan notes additional resources have been required for it, but indicates significant savings are also expected over the life of the plan through improved performance and therefore increased efficiencies. In the long term, the improvements made are expected to help avoid much greater "downstream" costs associated with a prevalence of mental disorders in children.

The Child and Youth Mental Health Service Delivery System

Services to address mental disorders are provided mainly by family doctors, psychiatrists, psychologists and clinical social workers in private practice. While a mental disorder may be detected or diagnosed by a family doctor, it is often the school or the parent who first voices concerns. If a child or youth is seriously ill and unable to manage at home, he or she may require an admission to hospital (either planned or on an emergency basis). Some larger communities have established dedicated hospital psychiatric units for children and youth. As well, B.C. Children's Hospital offers a specialized provincial facility for children and youth with mental disorders.

Services provided by the Ministry of Children and Family Development

The ministry provides the following mental health services for children and youth:

- Maples Adolescent Treatment Centre—This is a designated provincial mental health facility under the *Mental Health Act*. Services include short-term inpatient and outpatient multi-disciplinary assessments, care planning, intervention and ongoing outreach, consultation and respite. The target population is troubled young people (with significant psychiatric and behavioural challenges) 12–17 years of age, as well as those who committed a crime but are found to be either unfit to stand trial or not criminally responsible because of a mental disorder.
- Youth Forensic Psychiatric Services—Clinics and contracted service providers offer treatment and services for young offenders in custody in the community. An inpatient assessment unit for youth remanded for court-ordered assessments is also part of these services.
- Community-based child and youth mental health services (see the sidebar).

Community-based child and youth mental health services provided by the ministry

The Ministry of Children and Family Development delivers child and youth mental health services in communities through two main avenues:

- *Direct clinical services* are provided to a specific, identifiable and registered patient or to others involved in direct support of the patient on a voluntary basis. Referrals to the ministry's services can be made by children or youth themselves, or by individuals who are directly involved with them, such as family members and other agencies or service providers. The child/youth or parent/guardian must have knowledge of, and agree to, the referral before it is made.

  If a referral is judged to be inappropriate for the service in question, the ministry attempts to link the referring person with a more suitable agency or health provider. The services include intake, screening and referral, assessment and planning, treatment, case management, and clinical consultation. Cases are prioritized according to risk and impairment, with highest priority being given to individuals who are suicidal or experiencing extreme impaired functioning due to acute mental disorder. Clinical staff typically include psychologists, social workers, counsellors and nurses who provide services in a collaborative manner with the patient and/or family.

Background

- *Targeted community support* includes a range of services intended to support other service providers (such as school counsellors and family physicians) who may be working directly with individuals not registered in the ministry's community-based mental health system. Among these services are mental health consultation, program consultation, service system planning, community coordination, and education and health promotion —all targeted to supporting the mental health needs of children and youth.

Direct clinical services and targeted community support currently are provided through the following office structure (all figures as at April 2007):

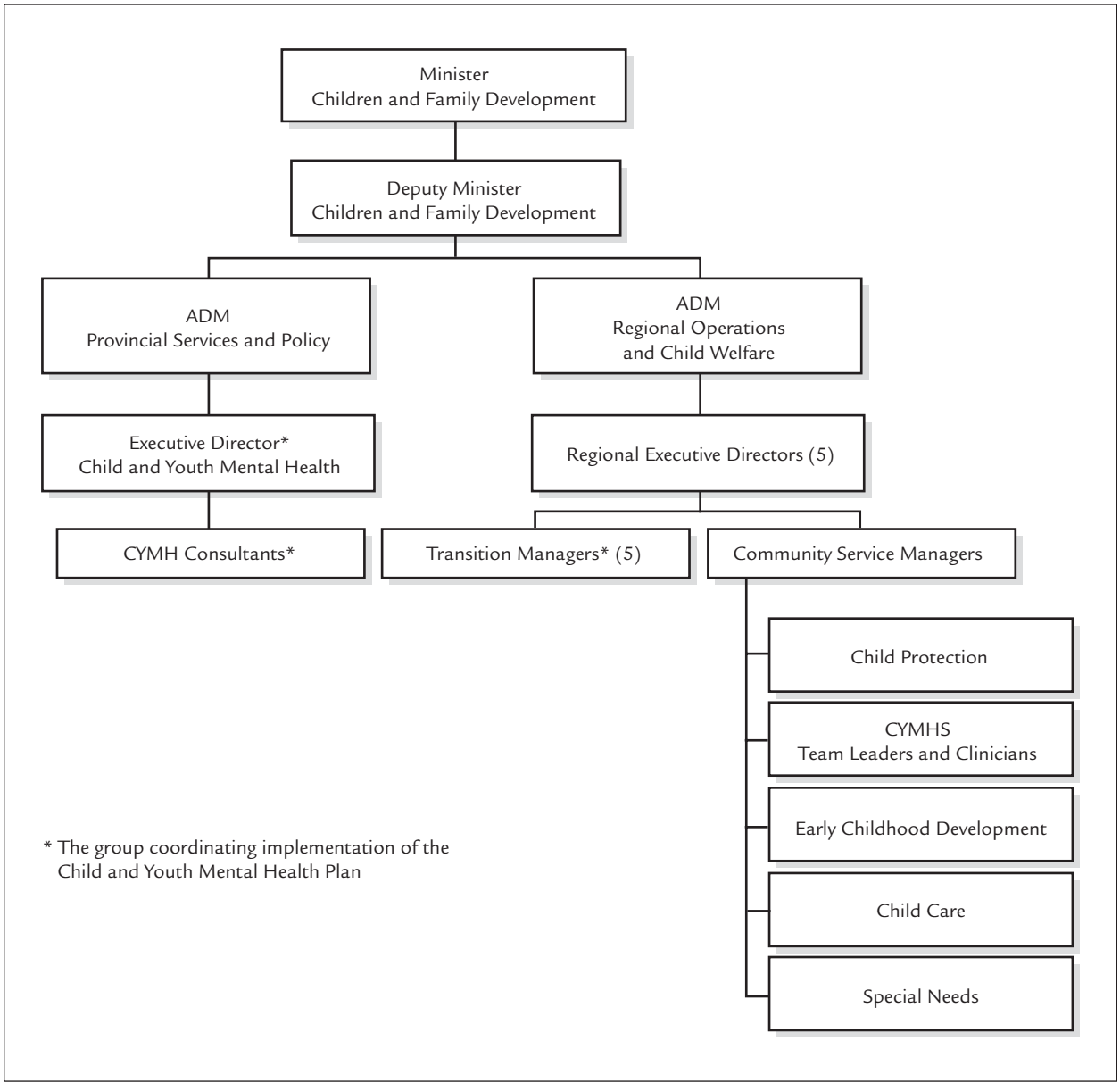
- a network of 83 community-based Children and Family Development offices located throughout the province, staffed with 329 full-time equivalent clinicians (employment of one clinician for one full year or equivalent thereof) (Appendix A);
- 129 contracted service agencies that extend the ministry's staffed programs in communities by providing specialized and mental health related community-based services (Appendix B); and
- 3 contracted agency equivalents of the ministry, located in Powell River, Prince George and Vancouver/ Richmond (Appendix C).

The community-based services are organized on a regional basis (Interior, Fraser, Vancouver Coastal, Vancouver Island and North). Each region has a Regional Executive Director who is responsible for the Child and Youth Mental Health Program—as well as for several other ministry programs. In addition, 14 staff members in the ministry's Provincial Services and Policy Branch are responsible for overseeing the plan's implementation (Exhibit 2).

The ministry estimates that it was serving about 11,000 clients before it began implementing the Plan in April 2003 and that about 20,000 clients were served during fiscal 2006/07. In contrast, the ministry has about 9,000 children in care thus highlighting the CYMH program's significance among ministry programs.

Exhibit 2

Partial organization chart of the Ministry of Children and Family Development as at November 2006, highlighting parties responsible for implementing the Child and Youth Mental Health (CYMH) Plan



Prepared by the Office of the Auditor General

Child and Youth Mental Health community partnerships

Meeting the mental health needs of children and youth can best be accomplished through ministry, family and community partnerships. Doing so, however, increases the complexity of the system (Exhibit 3). The many partners within the ministry provide services in the following areas:

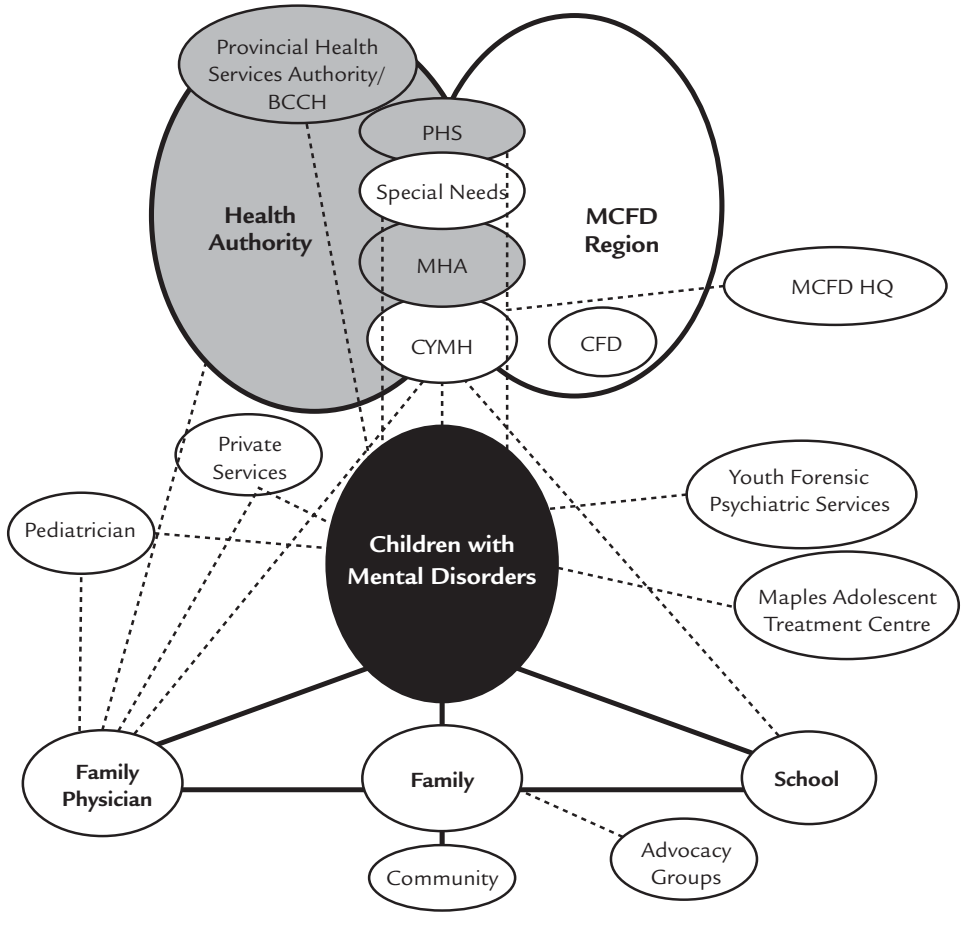
- child protection
- adoptions
- guardianship
- youth justice
- youth forensic

There are also many community partners external to the ministry, including:

- adult mental health
- addictions services
- schools
- hospitals
- public health services
- general practitioners
- psychiatrists
- community agencies
- advocacy agencies
- Aboriginal communities
- libraries
- recreation centres
- ethnic and cultural groups
- research and teaching institutions

Exhibit 3

Current organization of community-based child and youth mental health services in British Columbia



PHS – Public Health Services
Special Needs – services for children with development problems such as "autism"
MHA – Mental Health and Addictions Service
CYMH – Child and Youth Mental Health Services
MCFD – Ministry of Children and Family Development
CFD – Child and Family Development Services
MCFD HQ – the Provincial Services and Policy Branch
BCCH – BC Children's Hospital
Private Services – includes private psychologists, therapists, psychiatrists etc.
Note: Lines designate relationship type for child - solid is regular, dotted is potential

Prepared by the Office of the Auditor General

The ministry's budget for child and youth mental health services

According to the ministry, its Child and Youth Mental Health Program had a $37.1 million base budget before government began providing funding to implement the plan. Funding to implement the plan through fiscal 2007/08 will bring the total budget for the program to $85.4 million annually. This investment means that the base budget will have more than doubled since the beginning of fiscal 2005/06 when Phase 2 of the Plan began (Exhibit 4).

Exhibit 4

Child and Youth Mental Health Program funding by region, 2005/06–2007/08

Region	2005/06			2006/07		2007/08		
	Base ($000)	New Funds ($000)	2005/06 New Base	New Funds ($000)	2006/07 New Base	New Funds ($000)	2007/08 New Base	Percent Increase from 2005/06
Interior	6,432	2,548	8,980	2,797	11,777	3,042	14,819	230%
Fraser	9,215	4,350	13,565	5,536	19,101	4,084	23,185	252%
Vancouver Coastal	8,400	1,806	10,206	2,046	12,252	1,779	14,031	167%
Vancouver Island	8,049	1,405	9,454	1,566	11,020	2,789	13,809	172%
North	5,048	1,541	6,589	1,805	8,394	2,306	10,700	212%
Regional totals	**37,144**	**11,650**	**48,794**	**13,750**	**62,544**	**14,000**	**76,544**	**206%**
Structural costs (computer hardware, etc), wage compensation increase, Provincial Office, etc. paid during the period 2005/06–2007/08							8,886	
Ministry totals	**37,144**						**85,430**	**230%**

Source: Ministry of Children and Family Development

Background

Legislation and program responsibility

The primary provincial legislation relating to child and youth mental health is the *Mental Health Act*, administered by the Ministry of Health. The Ministry of Health is responsible for the Adult Mental Health Program and, before the creation of the Ministry of Children and Family Development in 1998, also administered the Child and Youth Mental Health Program.

The *Mental Health Act* does not focus on children and youth. Rather, its emphasis is on such matters as conducting hearings to decide the care, supervision and treatment of a mental health patient in a designated treatment facility. Community-based child and youth mental health services are not mentioned in the Act.

Our expectations

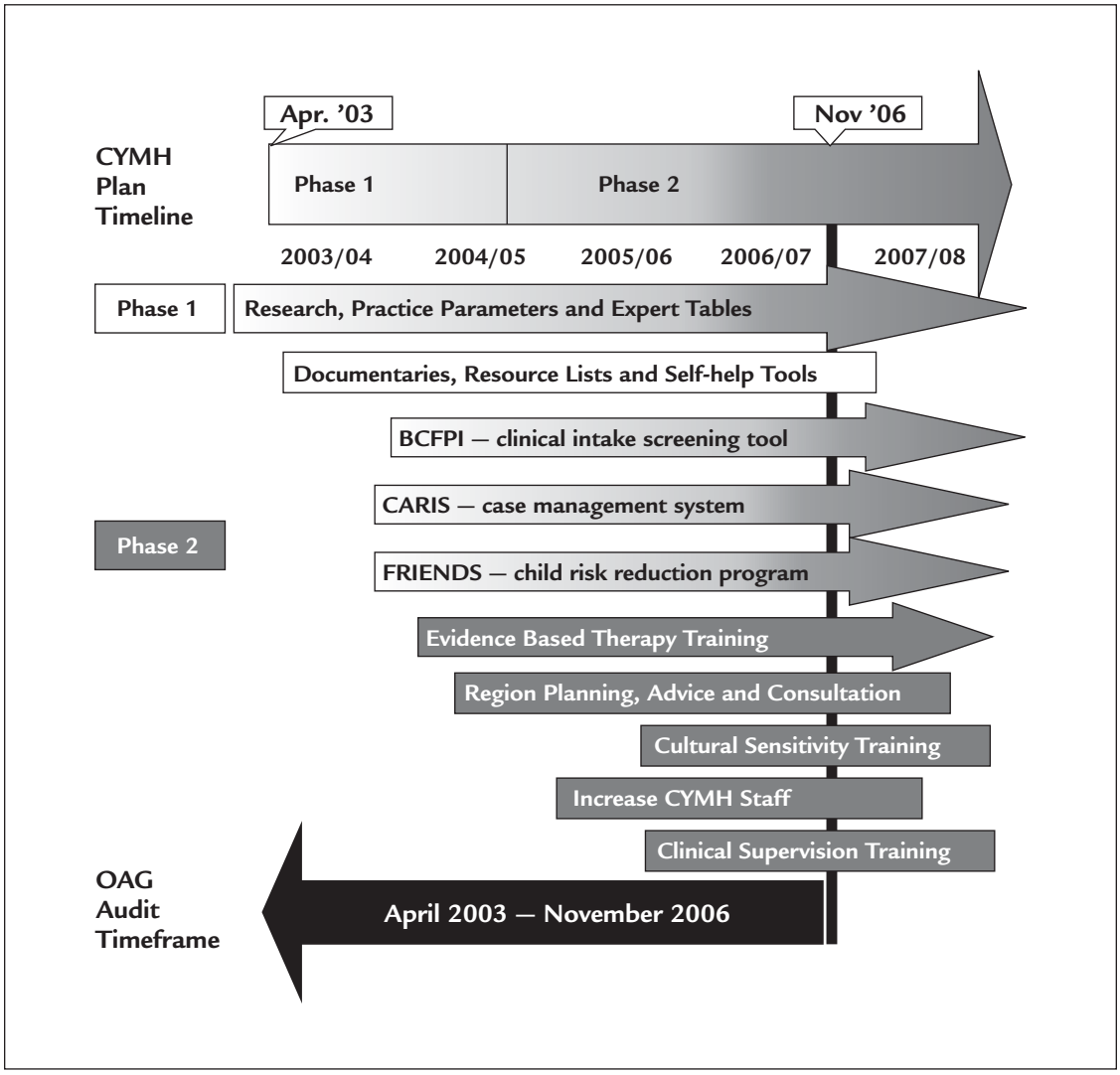
In a healthy community, it is in everyone's interest to ensure that all children and youth thrive. In British Columbia, it is widely accepted that the child and youth mental health system has historically not met stakeholder expectations. We therefore wanted to assess the steps being taken by the ministry to make improvements. Our expectations, worded as questions, include the following:

- Is the ministry's plan for improving the mental health outcomes of children and youth adequate?
- Is the ministry choosing appropriate key initiatives to implement the plan?
- Is the ministry adequately implementing its key initiatives?
- Is the ministry providing adequate accountability information about the plan's implementation?

Our audit was carried out from September through November 2006, whereas the plan's implementation covers the period from April 1, 2003, to March 31, 2008. As a result, our audit focuses on the processes used by the ministry to develop and implement the plan to date. We did not examine its outcomes because they cannot yet be fully evaluated. Exhibit 5, an overview of the status of the plan's implementation, also shows the time period of our audit.

Exhibit 5

Our audit period relative to the Child and Youth Mental Health Plan timeline



Is the ministry's plan for improving the mental health outcomes of children and youth adequate?

In February 2003, the Ministry of Children and Family Development, supported by the Ministry of Health Services, released the Child and Youth Mental Health Plan. We assessed whether the plan provides an adequate framework for improving the mental health outcomes of children and youth. Specifically, we assessed if the plan:

- reflects key stakeholder input for improving the system;
- has the support of individuals and groups who can help make the changes needed to improve the system;
- considers the adequacy of existing legislation;
- is clear on the mental disorders treated under the child and youth mental health program;
- considers the adequacy of resources in the program; and
- is consistent with the strategic directions of both the government and the ministry.

We concluded that the plan is an adequate plan for improving the mental health outcomes of children and youth. The plan was created through an extensive stakeholder consultation process and a knowledgeable external advisory group was established by government to oversee the plan's development. Resource requirements were satisfactorily considered and, to date, have been fully met by government. The plan is consistent with the strategic direction of both the government and the ministry and it continues to have the support of key stakeholders. While the plan adequately describes the mental disorders treated under the child and youth mental health program, clinician understanding of the ministry's policy on treating patients with both a mental disorder and a developmental or learning disorder varies.

No legislation exists to protect the services in the Child and Youth Mental Health program, but neither is there consensus among stakeholders about whether such legislation is needed.

We note that the organizational changes the ministry has begun making seriously concern many key stakeholders. They worry about the effect restructuring could have in this final year of the plan's five-year implementation. As the ministry completes the details of the changes, it should ensure that:

- adequate accountability mechanisms continue to exist between the regional operations and the provincial office so that plan objectives remain a priority, at least during the final year of implementation;

Is the ministry's plan for improving the mental health outcomes of children and youth adequate?

- there continues to be strong ministry leadership for child and youth mental health services;
- stakeholder concerns about the changes are addressed; and
- work begins to formulate new strategies to build on the accomplishments achieved under B.C.'s first Child and Youth Mental Health Plan.

The plan takes good account of key stakeholder input

The ministry involved a large number and wide range of key stakeholders in its efforts to develop the plan (see sidebar). Consultation with the individuals and group representatives was achieved through more than 700 questionnaires, focus group meetings, teleconferences, and individual interviews. The resulting qualitative and quantitative data was analyzed to determine priorities and themes related to the mental health system of care for children, youth and families. These priorities and themes were then used to develop the plan. Feedback from children, youth and families about the mental health system was obtained with the help of the British Columbia division of the Canadian Mental Health Association. The association assembled several separate focus groups—with consumer advocacy and support groups, with families, and with youth—in different regions of the province.

Stakeholder input to the Child and Youth Mental Health Plan

Input to develop the Child and Youth Mental Health Plan was sought from individuals and groups throughout British Columbia, including representatives from:

- Aboriginal communities;
- ethno-cultural organizations;
- the formal system of Child and Youth Mental Health Services within the Ministry for Children and Families: staff from Mental Health Centres, Youth Forensic Psychiatric Services, Maples Adolescent Centre, and the Family Court Centre;
- staff working in non-mental health programs within the Ministry for Children and Families (programs include Addictions, Youth Justice, Community Living, Child Protection, Adoptions, and Guardianship); and
- the broad service delivery system of care, which includes child and adolescent psychiatrists and other physicians, Ministry of Health, Ministry of Education, Ministry of Social Development and Economic Security, regional health authorities, Community Health Services Societies, and key stakeholders.

Despite its best efforts to obtain input from all key stakeholders, the ministry acknowledges that the consultation process did not work as effectively with some groups as with others. Youth, for example, were often difficult to reach and engage; some families

were reluctant to discuss their difficulties; and some Aboriginal and ethno-cultural groups did not respond well to the consultation methods used.

We found that the key themes drawn from the consultation are adequately demonstrated in the plan. For example, one theme was the requirement to identify ongoing education needs for the general public, mental health clinicians and other partners. The plan integrates this theme at the highest level objectives—which include risk reduction and capacity building—and right through to specific initiatives that provide a significant focus on delivery of education programs for the public, clinicians, and school teachers and counsellors.

As the plan's implementation has progressed, the ministry has continued to bring representatives of key stakeholder groups together in "expert tables" to inform the ministry's choice of program initiatives. Initially, the ministry had three expert tables: Anxiety, Depression and Early Psychosis. Subsequent expert tables have included Eating Disorders, Conduct Disorders, Dual Diagnosis (mental health and developmental disorder) and Concurrent Disorders (mental health and substance abuse). The work of the expert tables has been used to support the implementation of the specific program initiatives we discuss later in this report.

Expert tables are pools of experts involved in a particular area of practice. The areas of practice the ministry has focused on are those where a particular disorder is most prevalent in the population and those that have the highest impact on the individual and society. In putting expert tables together, the ministry seeks to have representation from practising experts, youth and researchers. The groups have been limited to about 10 participants.

At the regional operations level, staff consult with their key stakeholders when developing regional plans for child and youth mental health services. Services are provided by five regional operations corresponding geographically with the five regional health authorities. Each region includes numerous communities and there is a Child and Youth Mental Health office in many of them. During the plan's implementation, regions have been required to prepare a separate regional plan annually for child and youth mental health services. Communities consult with local stakeholders and this informs development of the regional plan. The Provincial Services and Policy group reviews regional plans to ensure that they are consistent with the overall plan.

Regional operations also have a separate consultation process to inform the development of regional Aboriginal plans for child and youth mental health services. Aboriginal service planning has been following a comparable process to that described above for the development of the regional plans. We found that although Aboriginal service plans were expected to be in place by December 2005, they exist in three of the five regions (Interior, Fraser and Vancouver Island). Some staff suggested to us that the timelines set for running the consultation process and developing Aboriginal plans was too short. Planning for the remaining two regions is continuing.

Support for the Child and Youth Mental Health Plan is high among individuals and groups who are working to improve the system

The ministry has adequately involved key stakeholders during plan development and implementation. For example, an external Advisory Group was established to oversee the plan's development and was made up of knowledgeable individuals. Also, a provincial network committee has been overseeing the plan's implementation and helping resolve impediments along the way. They include representatives from key stakeholder groups such as:

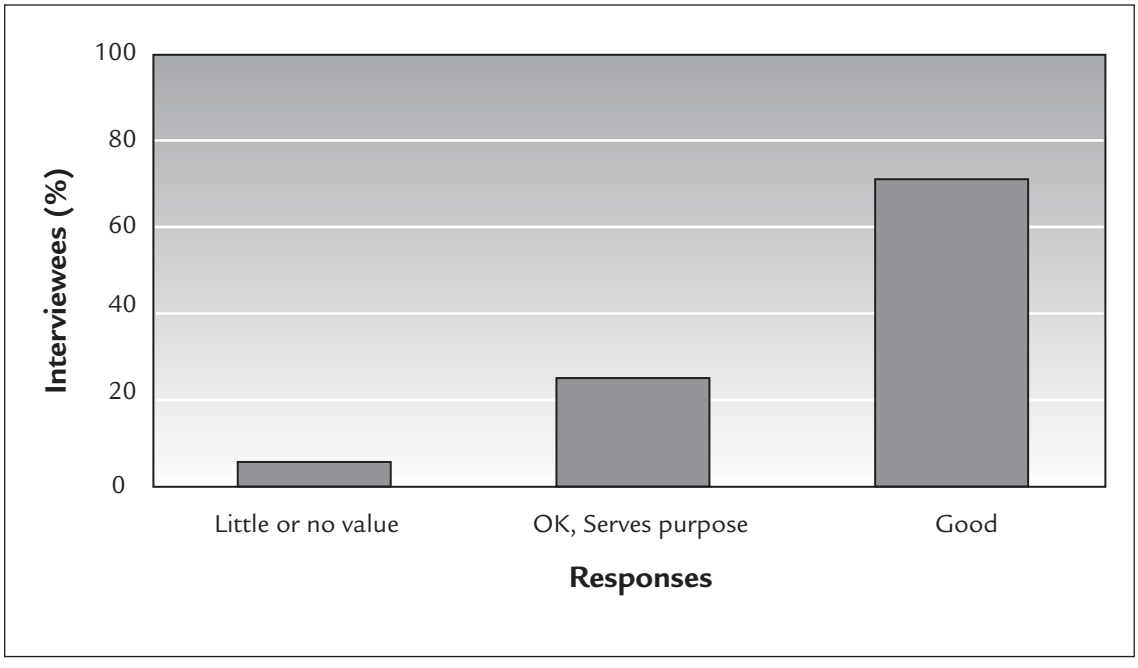
- ministries (Health and Education);
- government agencies, including all five regional health authorities, all five regional operations of the Ministry of Children and Family Development, Maples Adolescent Treatment Centre, Youth Forensic Psychiatric Services, and the province's Child and Youth Officer;
- BC Children's Hospital; and
- advocacy organizations (e.g., Canadian Mental Health Association, The F.O.R.C.E. [Families Organized for Recognition and Care Equality], and Vancouver Lower Mainland Family Support Services).

We sought the opinions of many key stakeholders and found that there continues to be a high level of support for the plan (Exhibit 6).

Is the ministry's plan for improving the mental health outcomes of children and youth adequate?

Exhibit 6

Interviewee responses to the question, "Is this a good plan for improving child and youth mental health outcomes?"



Prepared by the Office of the Auditor General

There is no consensus among stakeholders about whether legislation focused on child and youth mental health services is needed

The only legislation in British Columbia that addresses child and youth mental health services is the *Mental Health Act*—and it deals mainly with adults, focusing on the processes for institutionalizing patients and protecting their legal rights. No legislation aims specifically at ensuring that community-based mental health services are available to children and youth. Services are available only as a matter of government policy, and that policy can change over time.

As noted earlier, the attention paid to child and youth mental health services has long been inconsistent. This realization was a key reason for developing the plan. In November 2004, The Standing

Is the ministry's plan for improving the mental health outcomes of children and youth adequate?

Senate Committee On Social Affairs, Science And Technology chaired by The Honourable Michael J.L. Kirby released its interim report, *Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada*. The report referred to adult mental health services as an "orphan" of the Canadian health care system and child and youth mental health services as the "orphan's orphan."

We asked several key stakeholders whether they saw a need for child and youth-specific legislation, and found no clear consensus on the matter.

The plan adequately describes the mental disorders treated within the Child and Youth Mental Health program, but the ministry needs to reaffirm with clinical staff its policy on this matter

To better understand their patients' mental health problems and potential treatment, mental health professionals use the *Diagnostic and Statistical Manual of Mental Disorders*. The manual, published by the American Psychiatric Association (APA), covers all mental health disorders for both children and adults.

The manual uses a "multiaxial" approach to diagnosing mental health illnesses. Axis 1 includes various types of "mental disorders" (e.g., anxiety, conduct, attention, depressive and psychotic disorders), as well as developmental and learning disorders (e.g., autism disorders, which are typically first evident in childhood). Axis 2 includes what are frequently described as "personality disorders." Personality disorders are clinical syndromes that have longer-lasting symptoms and affect an individual's way of interacting with the world. Examples include paranoid, antisocial and borderline personality disorders.

The ministry has recognized that it needs to be clear about what disorders it treats under the Child and Youth Mental Health program. Accordingly, the plan perspective is inclusive—providing services to children with all the mental disorders described above in Axis 1. The ministry's *Child and Youth Mental Health Clinical Policy Manual* focuses the provision of services for children with developmental and learning disorders to those who have a co-existing mental disorder such as anxiety.

This approach has been adopted as a result of three key factors:

- Developmental and learning disorders are typically life-long conditions that are not a usual focus of mental health treatment in most jurisdictions.
- Historically, Child and Youth Mental Health staff have not had the mandate or the skills needed to work with patients having developmental and learning disorders.
- The ministry has decided to assist patients with developmental and learning disorders through its "Special Needs" division (funded separately from the Child and Youth Mental Health program).

Because a number of patients have "dual diagnosis" (that is, both a mental disorder and a developmental or learning disorder), the plan includes specific goals and objectives aimed at improving the skills of Child and Youth Mental Health clinical staff to better assist such patients and their families.

We asked clinical staff interviewees whether they are providing services to patients with developmental or learning disorders such as autism, mental handicap, developmental delay and fetal alcohol spectrum disorders. The clinician responses suggested to us that patients with the disorders mentioned may or may not receive services depending on the office location. We think that the ministry needs to ensure a consistent approach to treatment across the province.

We recommend that the ministry ensure that clinical staff clearly understand the ministry's policy on treating patients with both a mental disorder and a developmental or learning disorder to ensure a consistent approach across the province.

The plan adequately takes account of resource requirements

An important aspect of planning any program is to specify the resources that will be required to adequately put the program (or, in this case, the plan) into place. We found that, although the plan does not itemize the resources needed for its implementation, supporting documents show that the ministry carried out a reasonable analysis.

The analysis begins with a research estimate that the average community prevalence rate for mental disorders in children and youth is 15%. Anxiety, conduct, attention and depressive

disorders are the most common. Applied to British Columbia's 2002 population, this rate resulted in an estimate that approximately 140,000 children and youth in the province experience clinically notable mental disorders. The research also suggested that fewer than one in five children and youth with mental disorders received some form of specialized clinical service—indicating a significant unmet need. Input from the ministry's consultation process backed up this finding.

The ministry decided that the cost of meeting all of the unmet need would have been beyond what could be reasonably expected from government. It instead opted for a more cost-effective approach. In addition to increasing the availability of direct clinical services, the plan takes a population-based approach that uses (1) a mix of universal programs to build community capacity and (2) targeted interventions to reduce risk for some populations. This approach reflects the idea that prevention is typically less costly than treatment.

To estimate the cost of implementing the plan, the ministry used per-capita spending in other programs as a reference. At the time it was developing this plan, the government was also in the process of implementing an adult mental health plan that would increase funding from $116 per capita to $124 per capita, based on the projected adult population in 2008. The ministry's funding request for children and youth mental health sought to increase the level from $56 per capita to $122 per capita, based on the projected child and youth population in 2008. Thus, funding for the two programs was seen to be comparable. As well, the ministry made spending comparisons with Ontario at the time ($108 per child) and Alberta ($125 per child) to ensure its requested funding would bring British Columbia more closely in line with that of other jurisdictions.

Government approval of the plan noted that Phase 1 (April 1, 2003, to March 31, 2005) was to be funded through existing ministry resources, while Phase 2 (April 1, 2005, to March 31, 2008) would be funded through the ministry's three-year service planning process. The ministry also anticipated significant savings over the life of the plan because of the increased efficiencies. These efficiencies were to result from: improved performance by placing an emphasis on accessible community-based services; improved collaboration and coordination; better performance management; and the use of evidence-based practices. In the long

term, the improvements made are expected to help avoid the much greater "downstream" costs resulting from mental disorders.

The total plan funding requirements were described earlier (Exhibit 4). Government has provided the funding related to fiscal years 2005/06 and 2006/07, and the ministry reports that the final year of funding for fiscal 2007/08 is also expected to be met.

The plan is consistent with the strategic directions of both the government and the ministry

In a well-performing organization, strategic priorities should be consistent among all levels. We think that the direction provided by the Child and Youth Mental Health Plan must be clearly consistent with the direction provided by not only the ministry but also the government overall.

We found that the plan supports two of the provincial government's "five great goals": leading the way in North America in healthy living and physical fitness; and building the best system of support in Canada for persons with disabilities, those with special needs, children at risk, and seniors.

Similarly, the plan supports two ministry service goals, including:

- to identify and strengthen effective services for children, youth, families and communities in the province through a strengths-based, developmental approach; and
- to support Aboriginal people in designing regional models and implementing services for Aboriginal children, youth, families and communities.

We also noted that the Child and Youth Mental Health Plan has a strong focus on prevention, public awareness, evidence-based practices, use of an expert panel approach to identify initiatives, and the inclusion of school-based initiatives. These concepts are consistent with British Columbia's "Provincial Anxiety Disorder and Depression Strategies[1]," published in 2002.

We concluded that the plan fits well within the strategic priorities of both the government and the ministry.

[1] BC Ministry of Health. available at http://www.healthservices.gov.bc.ca/mhd/publications.html

Is the ministry's plan for improving the mental health outcomes of children and youth adequate?

Many key stakeholders are concerned about how the ministry's reorganization will affect plan objectives

The ministry's most recent reorganization began as we were completing our audit. According to the ministry, a desired outcome of the changes is to remove program boundaries and integrate services so that emphasis is placed on meeting client needs rather than protecting programs. However, stakeholders worry that the proposed changes could affect the plan's implementation by:

- removing or reducing the roles of key individuals who have been instrumental in developing the plan, leading its implementation, and providing a consistent voice for child and youth mental health clients at both the provincial office and regional levels; and
- altering the accountability structure established during the first four years of the plan—a structure that has helped to ensure that regional funds dedicated to achieving plan objectives are used for those purposes.

These changes are raising concerns among child and youth mental health key stakeholders, both inside and outside the ministry (Exhibit 7). They fear that the changes may take focus away from the plan objectives and put child and youth mental health services at risk of being overwhelmed by the ministry's "child protection focus."

As the ministry finalizes and implements its organizational changes, we believe it needs to keep adequate accountability mechanisms in place between the regions and the provincial office. This will help ensure that the objectives of the Child and Youth Mental Health Plan remain a priority at least for the final year of the plan. The ministry also needs to ensure that child and youth mental health services continues to have strong leadership, take steps to address the concerns of stakeholders about the changes, and to begin formulating new strategies to continue improving on the gains made to date.

We recommend that the ministry:

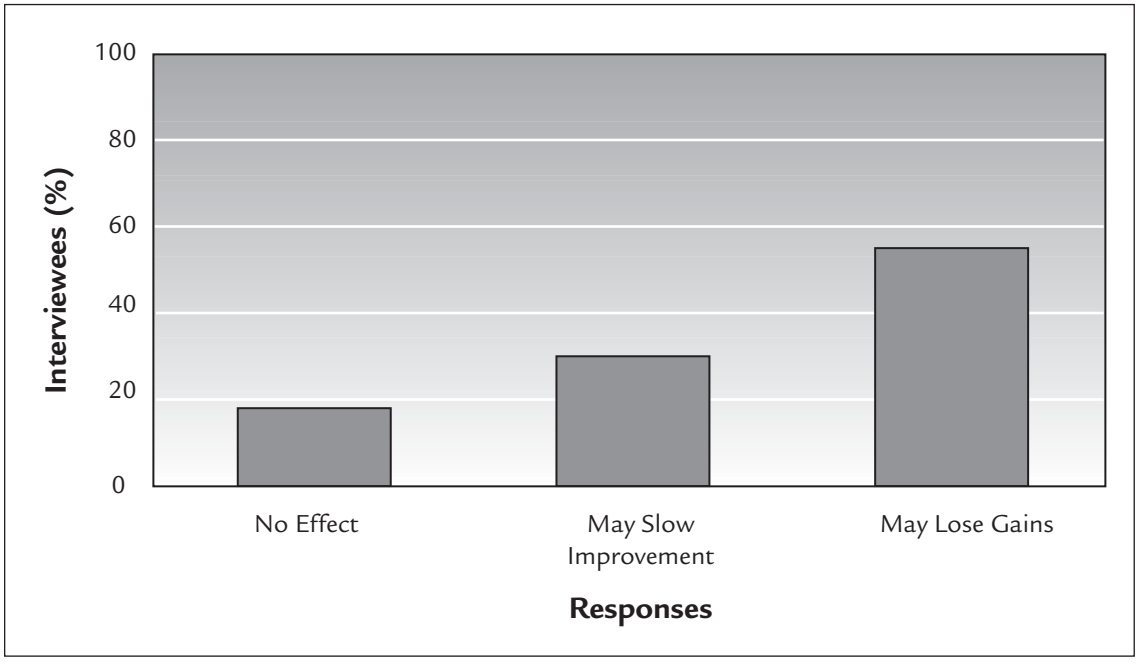
- **ensure that adequate accountability mechanisms continue to exist between the ministry's regional operations and the provincial office so that plan objectives remain a priority, at least during the final year of implementation;**

Is the ministry's plan for improving the mental health outcomes of children and youth adequate?

- **ensure that there continues to be strong ministry leadership for child and youth mental health services;**
- **address stakeholder concerns about the most recent reorganization; and**
- **begin formulating new strategies that will build on the accomplishments achieved under the province's first Child and Youth Mental Health Plan.**

Exhibit 7

Interviewee responses to the question "How will the current organizational changes affect the sustainability of plan-related accomplishments?"



Prepared by the Office of the Auditor General

Is the ministry choosing appropriate key initiatives to implement the plan?

The ministry defined each of the four goals in the Child and Youth Mental Health Plan in terms of a series of implementation objectives. It then chose initiatives to help meet those objectives (Exhibit 8). We expected the ministry to have adequate processes to ensure that the initiatives chosen are appropriate to meet the goals and objectives. Specifically, we expected to find that the initiatives being implemented are:

- consistent with the goals and objectives articulated in the plan, and
- adequately supported by favourable cost-benefit analyses, research or key stakeholder views.

We concluded that the ministry has adequately ensured that the key initiatives it is implementing to improve the mental health outcomes of children and youth are consistent with the goals and objectives articulated in the plan and are appropriately supported. One gap is the lack of a clear strategy to bring about meaningful inter-sectoral collaboration, particularly with physicians.

The initiatives to improve treatment and support services are consistent with the plan goal and objectives and are appropriately supported

To help improve mental health treatment and support services for children and youth, the plan lists four implementation objectives:

- ensuring a basic range and level of core services in every region,
- reducing the gap between need and service capacity,
- promoting evidence-based practice, and
- providing culturally appropriate and accessible services.

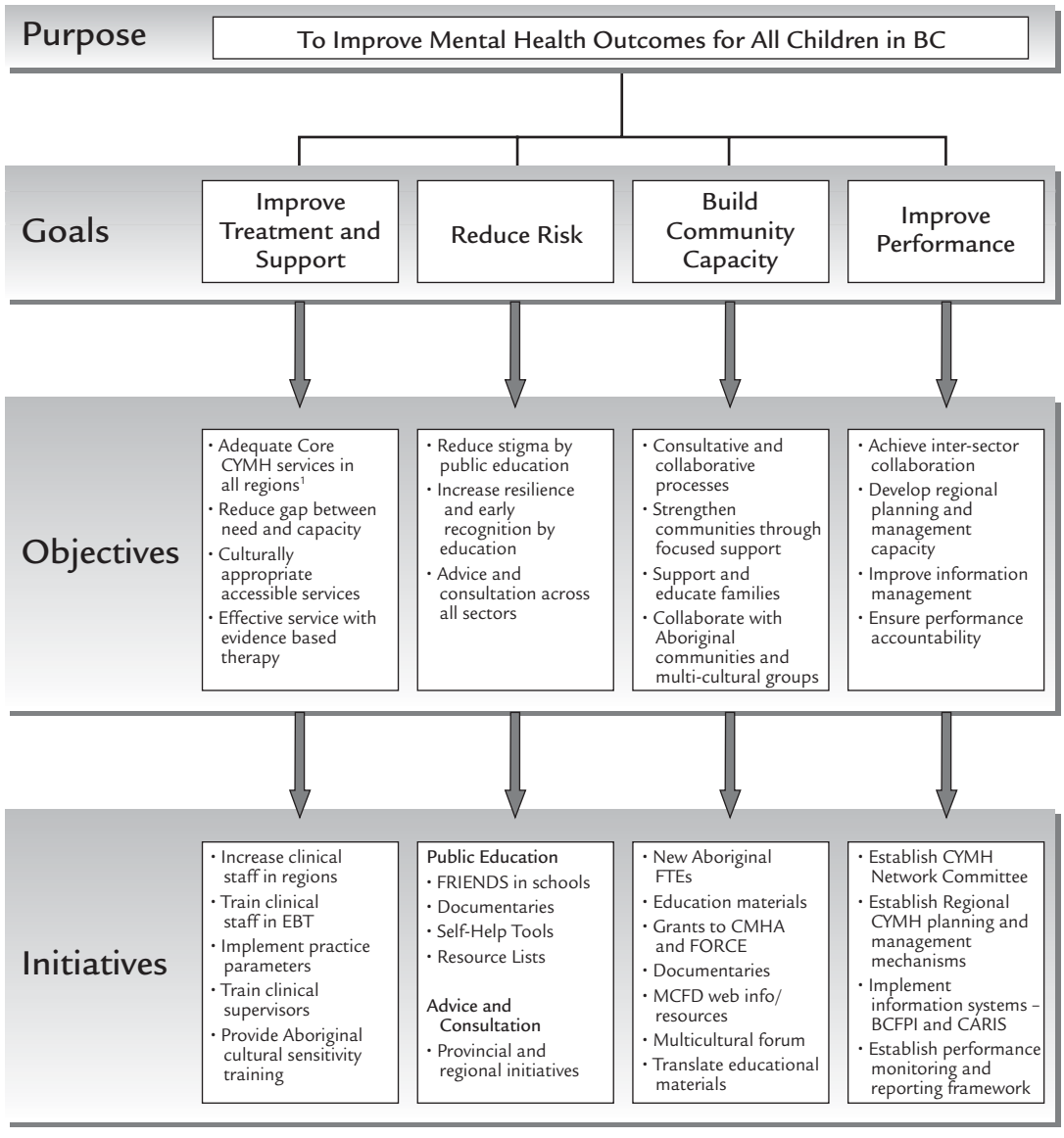
Ministry initiatives to achieve the objectives include:

- significantly increasing the number of clinicians to improve service times and ensure core services are available in each region;

Is the ministry choosing appropriate key initiatives to implement the plan?

Exhibit 8

The Child and Youth Mental Health Plan at a glance



[1] Core CYMH services are consultation; community-based assessment/treatment; family development; day treatment; crisis intervention/stabilization; and residential.

Prepared by the Office of the Auditor General

Is the ministry choosing appropriate key initiatives to implement the plan?

- implementing an extensive training program for clinical supervisors, clinicians and contract-equivalent staff that focuses on evidence-based therapies—notably, cognitive behavioural therapy, interpersonal psychotherapy, dialectical behaviour therapy and early psychosis intervention;
- implementing practice parameter guidelines in priority areas of practice to help clinicians better serve their patients;
- providing clinical supervision training for supervisors to help ensure patients receive the right quality and quantity of treatment and support services; and
- providing Aboriginal cultural sensitivity training.

We found that, during plan development, the ministry was already identifying initiatives in priority areas. All of the above initiatives are detailed in the plan as priorities for implementation and are supported by the consultation and research underpinning the plan.

We provide a brief overview of each of these initiatives below:

Clinical staffing recruitment initiative

The plan recognizes the need to improve accessibility of appropriate services when and where they are needed. To that end, it set out to provide a basic level and range of core services in every region. These services include:

- consultation
- community-based assessment and treatment
- home-based outreach
- family development services
- day treatment
- crisis intervention and stabilization
- residential services

The plan reflects that there are significant gaps between the need for services and the ministry's ability to meet those needs. Accordingly, a plan priority is to increase permanent clinical staff in the regions. We found that, during fiscal 2005/06, the ministry established 103 new clinician positions and was able to fill 92 of them. And, during fiscal 2006/07, the ministry established an

additional 91 new clinician positions and filled 89 of them as of September 2006. Given that the ministry had about 250 clinician positions before the plan's implementation began, this new staffing level represents a substantial increase.

We noted that the ministry used a socio-economic model to allocate resources to the five regions. As a result, more than half of the new clinical staff have gone to the Fraser and Interior regions. The Fraser region has been one of the fastest growing areas of the province, and the Interior has been chronically under-serviced. The ministry has also established 11 new service locations throughout the province.

Key stakeholders support this initiative to significantly increase clinical staff numbers.

Training initiatives

Four training initiatives being implemented province-wide by the ministry to improve mental health services are discussed below.

Evidence-based therapies training

The research on which the plan was built stressed the importance of evidence-based treatments. The plan recognizes that recommended practices change as research provides new evidence about the best approaches to treating the variety of children's mental disorders. Accordingly, a priority in the plan is a training program to ensure that clinicians are kept informed of, and skilled in, evidence-based treatments.

We found that the ministry has been providing training in evidence-based therapies, and that cognitive behavioural therapy is now considered a core training requirement for all clinical staff. Also, more advanced forms of evidence-based therapies are available to clinicians wanting to advance their skills. More than 50 training events had been conducted as of September 2006.

Key stakeholders support this focus on evidence-based treatments and the associated training provided to clinical staff.

Is the ministry choosing appropriate key initiatives to implement the plan?

Practice parameters

Because research results are constantly changing, the plan recognizes the need to update practice parameters regularly to reflect new findings. We found that the ministry has draft guidelines on the following disorders:

- attention-deficit/hyperactivity disorder
- conduct disorder
- depression
- obsessive-compulsive disorder
- schizophrenia

The plan directs that draft guidelines should also be completed on other anxiety and mood disorders, concurrent disorders (e.g., mental health and substance abuse), eating disorders, neuro-developmental disorders, emotional and behavioural problems, parenting problems and child maltreatment (the latter two as they relate to mental disorders). The overall aim is to create a dynamic and sustainable model for making the best research evidence on child and youth mental health widely available on an ongoing basis. The implementation of evidence-based practice parameters is expected by the ministry to result in more effective and efficient practice, and to introduce a degree of standardization in treatment approaches.

We found that clinical staff accept the importance of practice parameters.

Clinical supervision training

The early consultation process indicated that many ministry clinicians, particularly in more sparsely populated areas, were working without appropriate mental health supervision. The plan notes that it is imperative that appropriate supervision by clinical leaders trained in mental health care be provided throughout the province. We found that the ministry has been providing this training. In the fall of 2006, for example, three training events were carried out.

Clinical staff told us that, overall, they accept the need to improve formal systematic clinical supervision. As well, they consider the competency-based clinical supervision model chosen for

implementation to be appropriate to the child and youth mental health setting and good quality, representing an opportunity to improve service quality and effect.

Aboriginal cultural sensitivity training

The consultation process also identified that those in Aboriginal communities were not accessing ministry services to the extent expected. Part of the reason given was that services were not seen to be culturally sensitive. Therefore, in mandating that the ministry must provide a basic level and range of core services in every region, the plan states that culturally appropriate approaches must be developed. Such training has begun and will likely be mandatory for all clinicians. Three such training events were carried out in the fall of 2006.

Clinicians reported to us that they thought the cultural sensitivity training was adequate and the ministry lead for the training told us that ways to improve the training were being pursued.

The initiatives to reduce risk are consistent with the plan goal and objectives and are appropriately supported

The plan states that some children are at greater risk than others for acquiring a mental disorder. Research indicates that these children and their families benefit from targeted efforts to reduce their risk and prevent problems earlier where possible. Accordingly, the plan lists two implementation objectives to reduce risk factors in children and families, strengthen resilience and enhance protective factors:

- initiating provincial *public education programs* to:
  - facilitate early recognition and preventive intervention that reduce the stigma associated with mental health problems, and
  - promote approaches that increase protective factors in the lives of children and families; and
- providing mental health *expert advice and consultation* to programs and services across all related sectors, including public health and primary care, early child development,

schools, community living, child protection, addictions, youth justice, adult mental health, hospitals, and crisis and residential services.

Public education initiatives

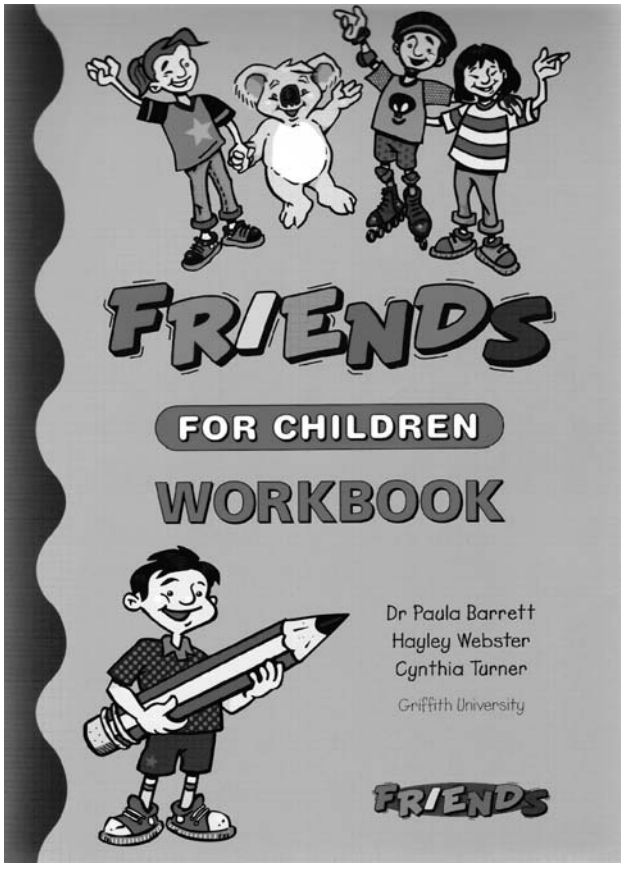
Four initiatives being implemented province-wide by the ministry to educate the public about mental disorders in children and youth are discussed below. We believe that all of these are consistent with the plan's risk reduction goal and objectives.

The FRIENDS program initiative

The ministry's most ambitious risk reduction initiative is the FRIENDS program, a school-based early intervention and prevention program developed in Australia. The ministry researched this program, which experience proves to have been effective in reducing the risk of anxiety disorders and building resilience in children. It teaches children how to cope with fears and worries and equips them with tools to help manage difficult situations, now and later in life.

The FRIENDS program is co-sponsored by the Ministry of Children and Family Development and the Ministry of Education. School professionals may deliver FRIENDS as a classroom-based universal prevention program or as an early intervention program to children who are at higher risk for anxiety disorders. The ministry's ultimate goal is to expose all British Columbia children in grades 4 and 5 to FRIENDS, to provide them with life skills that will help them cope with worries and reduce their risk of developing an anxiety disorder. The ministry reported that 1,696 school professionals had been trained and 47,500 students had been exposed to the program across the province as of September 2006.

Is the ministry choosing appropriate key initiatives to implement the plan?



Courtesy of Ministry of Children and Family Development

The Friends program is designed to help young people cope with and manage anxiety and depression both now and in later life

The ministry is also implementing a version of the FRIENDS program with an Aboriginal focus. As of September 2006, five schools in Vancouver and three in Prince Rupert had participated in the program—in all, 30 school personnel were trained and 225 children learned about FRIENDS.

A parent training component to FRIENDS aims at educating families and enabling them to support children with anxiety disorders. The ministry contracts The F.O.R.C.E. to deliver this part of the program. During 2005/06, parent training sessions were delivered in 15 sites across the five regions (three per region) and plans call for an additional 15 sessions in 2006/07.

The program has a very high level of support from key stakeholders, including representatives in the schools that are using the program.

Is the ministry choosing appropriate key initiatives to implement the plan?

Support for the FRIENDS program is widespread:

- The World Health Organization recognizes FRIENDS as an effective prevention program for anxiety disorders in children and youth.
- Implementation of FRIENDS was among the first recommendations of the Anxiety Expert Table who considered it appropriate for universal implementation in British Columbia.
- FRIENDS is considered to be cost-effective. Research has shown that a large number of children are affected by anxiety disorders and the cost of not providing treatment is significant later in life.
- Research supports the use of cognitive behavioural therapy in treating anxiety disorders in children and youth, and FRIENDS is based on a cognitive behavioural therapy model.

TV documentaries

An important public education initiative involves TV documentaries. The Knowledge Network, in partnership with the ministry and the former Mental Health and Community Consultation Unit at the University of British Columbia, has produced four documentaries on child and youth mental health:

- *Beyond the Blues: Child and Youth Depression*
- *Fighting Their Fears: Child and Youth Anxiety*
- *Map of Mind Fields: Managing Adolescent Psychosis*
- *Struggle for Control: Child and Youth Behaviour Disorders*

Through the personal stories of young people and interviews with parents and experts, these documentaries outline the early signs, symptoms and treatment of four mental disorders. The documentaries are available in DVD and VHS formats from the National Film Board or can be viewed online.

The ministry has made copies of the documentaries available to the main branches of all British Columbia public libraries. Some ministry clinicians told us they use the films as teaching tools for patients and their families.

We found that the films have been well received by clinicians and the public. Periodically repeated by the Knowledge Network, the films are accessible on both the Knowledge Network's and ministry's websites.

Self-help tools

Increasing knowledge about mental health issues in children and youth is another public education initiative laid out in the plan. *Dealing with Depression: Anti-Depressant Skills for Teens*, for

example, is a guide intended to assist 13- to 17-year-olds who suffer from depression or who believe they have an early or mild form of depression. The guide was created by mental health experts and clinical psychologists from British Columbia. Along with answers to many common questions about teen depression, it contains interactive worksheets and links to other sources of information. The guide is available in printed and web versions and it has been distributed to general practitioners and school counsellors. Clinical staff also make them available to clients.

As of September 2006, about 12,300 copies of the guide had been distributed, 3,870 copies of the web-based writeable version had been downloaded (by 368 visitors), and 2,330 copies of the printable version had been made (by 177 visitors).

Resource lists

Resource lists — of recommended books and websites — are also aimed at increasing public education. The ministry, in collaboration with McMaster Children's Hospital, the Ministry of Community Services and the B.C. Library Association, created book lists that target three common problems affecting many children, youth and families in the province:

- mood problems and depression,
- anxiety, and
- behaviour problems.

The books on the lists have been extensively reviewed by parents, families and professional groups such as the Canadian Pediatric Society. The lists also contain pertinent website addresses. The ministry has ensured that the books on the lists are available at all main library branches in British Columbia. The ministry has also distributed the lists (in the form of tear-off pads) to family doctors, and clinical staff have them on hand to distribute to patients and parents when they first make contact with the program.

Support for resource lists includes:

- The Anxiety Expert Table recommended book lists.
- Book lists are used in Ontario.
- The initiative is a low-cost measure for getting information into the hands of professionals, children and families.

Is the ministry choosing appropriate key initiatives to implement the plan?

Expert advice and consultation initiatives

In addition to using public education to help reduce risk, the plan also sets out to provide information, support and consultation to service providers who work with broad populations of children to assist in early identification of emerging mental disorders. To that end, the ministry has chosen two main initiatives, which we found to support the objectives of the risk reduction goal. They include:

- Creation of new risk reduction/early intervention positions throughout the province — The ministry reports that, as of September 2006, three full-time-equivalents (FTEs) were placed in the Interior region, six in the Fraser region and two in the Vancouver Island region. Early psychosis services are funded and delivered in collaboration with the Fraser Health Authority.
- Delivery of three infant mental health training events to increase the expertise of ministry practitioners in this area — These were being planned during the fall of 2006.

Regional risk reduction initiatives

In addition to its province-wide initiatives, the ministry also sponsors numerous region-specific activities to help meet its risk reduction objectives (see Appendix D). The regional activities target both Aboriginal and non-Aboriginal populations and encompass educational as well as expert advice and consultation initiatives.

We found that there is adequate support for regionally determined risk reduction initiatives. The Provincial Services and Policy staff, who have been guiding the plan's implementation, set a target requiring that regions use 15% of their budgets on risk reduction activities. Accountability requirements help ensure that the target is met. Regions must prepare annual service plans that are based on consultation and analysis of the needs and gaps at the community level. As well, community plans are rolled up into a regional plan which must be approved by the Regional Executive Director and the Regional Transition Manager. Regional plans are then reviewed by the ministry's Provincial Services and Policy group to ensure that the plans meet the overall requirements of the Child and Youth Mental Health Plan (including allocating 15% of the regional budget to risk reduction). Finally, the regional plans must be approved by the Executive Director, Child and Youth Mental Health and the Assistant Deputy Minister, Provincial Services and Policy.

Is the ministry choosing appropriate key initiatives to implement the plan?

The initiatives to build community capacity are consistent with the plan goal and objectives and are appropriately supported

To help build individual, family and community capacity to care for children, the plan listed the following implementation objectives:

- providing mental health consultation to those working in early child development, primary health care, schools and other community programs and organizations involved with the healthy development of children and families;
- supporting and educating families and promoting their full participation in all aspects of planning for children's health, well-being and development;
- working with community organizations and institutions to address the social determinants of health, build resiliency and reinforce protective factors that support children and families experiencing mental disorders;
- providing increased collaboration and resources to aid Aboriginal communities in developing mental health programs based on their individual cultures and needs, as well as to ensure full access by Aboriginal children to culturally competent programs and services in the mental health system; and
- reaching out to other cultural groups that under-utilize services.

Ministry initiatives to achieve these objectives include the following:

- *Creating new Aboriginal mental health positions*—Under the plan, 43.2 full-time-equivalent (FTE) Aboriginal mental health positions were filled or posted as of September 2006.
- *Establishing a 1-800 line for affected families*—The ministry funds a provincial 1-800 line to provide families with resource information and to connect callers with The Families Organized for Recognition and Care Equality Society for Kids Mental Health Care (The F.O.R.C.E.).
- *Producing a Knowledge Network documentary series* (as discussed earlier in this report)
- *Developing web-based information and resources for service providers and the public*—In 2004, a new ministry website was developed to provide public information on achievements made under the plan. The website

also provides information for service providers, parents and youth, including links to related resources and research. The ministry estimates there are an average of 65,000-70,000 visits monthly to the website.

- *Developing educational materials*—The ministry has developed and distributed book lists targeting three common mental health problems affecting children: mood problems and depression, anxiety, and behavioural problems (all discussed above.) A new brochure—"What Is Child and Youth Mental Health Services?"—was also developed by the ministry to help children, youth and their families access regional mental health services.
- *Conducting multicultural related activities*—Two main activities have been carried out by the ministry to build capacity in the multicultural community:
  - A Child and Youth Mental Health forum was held in December 2005. Recommendations from the forum were used to inform ministry efforts to improve multicultural service response in providing mental health care to children and youth.
  - Educational materials have been translated into a variety of languages, including Cantonese, Mandarin, Punjabi, Korean, Farsi, Vietnamese, French and Spanish.
- *Awarding depression screening grants*—Grants have been provided to the Canadian Mental Health Association for fiscal years 2005/06 and 2006/07 in support of depression-screening day events.
- *Sponsoring a variety of regional capacity-building initiatives*—The ministry sponsors numerous other regional activities to help meet its capacity-building objectives (see Appendix E). The regional activities target both Aboriginal and non-Aboriginal populations.

As with risk reduction activities discussed earlier, the ministry also expects each of the five regions to spend 15% of its mental health services budget on individual, family and community capacity-building activities. The regions have flexibility in what these activities are, and the same ministry accountability processes as described under risk reduction (above) ensure that the activities meet the objectives of capacity-building.

Is the ministry choosing appropriate key initiatives to implement the plan?

Courtesy of Ministry of Children and Family Development

Many regional activities focus on building individual, family and community capacity to care for children

The initiatives to improve performance are consistent with the plan goal and objectives and are appropriately supported

The plan notes that accountability and outcome monitoring are key issues that need to be addressed across all systems and sectors serving the mental health and related needs of children. In particular, it calls for new systems for coordinating services and overseeing accountability for improved outcomes, as well as comprehensive information systems that monitor not only services provided, but all broad outcomes across related sectors.

To help improve performance for children and youth mental health care, the plan lists the following implementation objectives:

- achieving inter-sectoral collaboration to support implementation of the plan;
- developing regional planning and management capacity; and
- improving clinical and management information infrastructure.

Is the ministry choosing appropriate key initiatives to implement the plan?

Ministry initiatives to achieve these objectives are discussed below.

Inter-sectoral collaboration

A key ministry initiative to improve inter-sectoral collaboration was creating the Child and Youth Mental Health Network, a senior inter-jurisdictional committee of 23 members established to engage the broader health and social service community in the implementation of the plan. The network, which has met three times a year since 2004, provides a forum for inter-jurisdictional guidance on the implementation of the plan. It has worked on various high priority policy and performance management topics such as:

- a policy framework for youth transition to adult mental health services,
- child and youth mental health performance indicators,
- tertiary hospital services at B.C. Children's Hospital,
- primary care renewal and children's mental health,
- physician education on mental health, and
- child and youth mental health prevention and core public health functions.

Members of the Child and Youth Mental Health Network include:

- the former Child and Youth Officer,
- the Provincial Health Officer,
- an Aboriginal representative and other multicultural representative, and
- representatives from:
  - the province's health authorities
  - Ministry of Children and Family Development regions
  - Ministry of Education
  - Simon Fraser University and University of Northern British Columbia
  - The F.O.R.C.E. family and child advocacy organization
  - Canadian Mental Health Organization

The network is co-chaired by the Ministry of Health and the Ministry of Children and Family Development.

Most members of the network told us they support it as an aid to improving inter-sector collaboration, but many said they feel it could be more effective. The concept is an established process in other parts of government. In terms of the network's helping to resolve inter-jurisdictional issues, many members gave

a mixed assessment. Most are of the view that the network has turned into an information-sharing vehicle rather than being the problem-solving forum it was intended to be.

Given the significant role of the many groups (particularly physicians) involved in providing mental health services and the complexity of the relationships, we think that the ministry needs a clear strategy to outline how it plans to bring about meaningful inter-sectoral collaboration to improve services. As a first step, the ministry should do enough preliminary work to decide where and how to focus its efforts.

We recommend that the ministry develop a clear strategy to bring about meaningful inter-sectoral collaboration, particularly with physicians.

Regional planning and management capacity

The ministry has adopted several measures to develop regional planning and management capacity. One, as noted earlier, is that of establishing processes for developing and approving regional plans to ensure they are consistent with the plan's objectives and are adequately supported. Other measures include holding regular meetings with service partners, setting up community-based network committees, integrated case management activities, and co-locating operations with service partners. New services include establishing jointly funded positions and initiatives.

New resources have been committed by the ministry to help improve inter-sector collaboration and coordination of services in the regions. Child and youth mental health services before the plan were reportedly insufficient to enable participation in multi-disciplinary initiatives within and outside the ministry. A Child and Youth Mental Health Team Leader position, for example, with responsibility for community level collaboration and coordination, is in place for all areas of the province. Also, a regional Child and Youth Mental Health Manager position, with responsibility for regional and cross-regional collaboration and coordination, has been confirmed in several (though not all) regions.

We also noted that five Regional Transition Managers were appointed to manage the implementation of the plan regionally. The Regional Transition Managers have been instrumental in

putting the plan into effect in the regions. One region, we note, has decided not to continue with this position for the final year of the plan's implementation.

Several steps have also been taken to improve planning for Aboriginal mental health care, all of which support the plan's objectives for the improved performance goal. A provincial Aboriginal mental health planning committee has been established; Aboriginal planners have been hired in all five regions; and Aboriginal mental health plans have been approved in three regions, Fraser, Interior and Vancouver Island.

Improved clinical and management information infrastructure

The plan notes that the existing information management systems are inadequate to meet the ministry's needs. Therefore, the ministry is implementing two new major systems improvements.

Brief Child and Family Phone Interview (BCFPI)

The BCFPI is a computer-assisted interview instrument for screening mental health intake and outcomes. It is currently being used at health organizations in Alberta and Ontario. The ministry has adapted the half-hour BCFPI for British Columbia, pilot-tested it, and implemented it in all ministry offices (this includes providing staff training). More recently, the ministry has been developing aggregate management and clinical information reports and training staff on how to use these. The BCFPI is expected to provide summary results to clinicians, enabling them to monitor caseloads and to provide statistical reports (organized by clinician, service location, region and provincial total).

Main uses of the Brief Child and Family Phone Interview (BCFPI):

- Intake screening—capturing data and making decisions about whether, when, how, and where a case should move through the service system
- Outcomes assessment and benchmarking—determining how a client's mental health and functioning changes between the beginning and end of service and through follow-up
- Service system management—developing systemic strategies to optimize system efficiency and responsiveness

Is the ministry choosing appropriate key initiatives to implement the plan?

We found that clinical staff support the need for a screening tool, but a significant number have concerns with the BCFPI being the chosen tool. Among the comments we heard from Child and Youth Mental Health clinical staff about the BCFPI:

- Some were concerned about the time it takes to enter data into the BCFPI (more than 30 minutes)—time taken away from seeing patients.
- Some said the BCFPI is not an effective screening tool, sometimes not identifying, for example, those with eating disorders, psychosis or substance abuse.
- Some questioned the validity of the treatment guidance provided by the BCFPI system and admitted ignoring the guidance.

The ministry selected the BCFPI initiative based on an independent review. Six potential screening tools in all were evaluated and the BCFPI was found to best meet the ministry's criteria. As a result, the ministry is committed to using the BCFPI and expects that staff acceptance will improve once they begin using the reports and see how the tool will assist them.

Community and Residential Information System (CARIS)

This other major information-related initiative is a case management system. Historically, Child and Youth Mental Health patients have been registered in the Patient Information Management System (CPIM), managed by the Ministry of Health. Limitations of that system and its imminent retirement led to selection of a new clinical and management information system. No "off the shelf" system was available, therefore making development of a new system necessary. As of November 2006, the ministry had completed implementation of CARIS in pilot sites and one region. Training and implementation in the remaining regions was expected to take place in early 2007. Initial staff response to the new system has been favourable.

Is the ministry adequately implementing its key initiatives?

Implementing the Child and Youth Mental Health Plan is an enormous undertaking, involving both province-wide and regional initiatives. The provincial initiatives focus on increasing resources that benefit communities, families and the public across the province. The regional initiatives focus on responding to the unique needs in local areas. Large staff increases, a shift to evidence-based practices, development and implementation of new information systems, and extensive regional planning are just some of the efforts that have been undertaken since the plan's start.

Good management practice requires that significant program changes be adequately planned and monitored. Doing so helps to ensure that the desired changes are made economically and efficiently and, in this case, as least disruptively as possible to children and youth needing mental health services.

To ensure that the ministry is adequately planning and monitoring implementation of the plan's initiatives, we expected there to be:

- plans to guide implementation; and
- adequate monitoring processes to help ensure that the initiatives are being implemented as intended, including such processes as:
  - periodic review of implementation progress;
  - adjustment of implementation, based on monitoring results; and
  - adequate oversight of the implementation and monitoring processes.

We concluded that the ministry is adequately implementing its key initiatives, although there are several areas for improvement. Approved plans are in effect to guide implementation of key initiatives, and monitoring processes are being used to help ensure progress. Where weaknesses need to be addressed are in the implementation of evidence-based treatments, clinical supervision training and the FRIENDS risk reduction initiative. Efforts to increase staff acceptance of the new computerized client intake tool—Brief Child and Family Phone Interview (BCFPI), discussed in the previous section—are also required.

Is the ministry adequately implementing its key initiatives?

The ministry has an approved charter that continues to guide the implementation of the plan

As noted before, implementation of the plan is in two phases. Phase 1, covering fiscal years 2003/04 and 2004/05, focused primarily on improving performance in the system (e.g., using evidence-based treatments). Phase 2, covering fiscal years 2005/06 through 2007/08, was to be informed by the results of Phase 1. It has involved shifting the focus to strengthening and increasing the capacity of the children's mental health service system (e.g., increasing clinical staff) so that the gap between need and capacity will be substantially reduced.

To help guide the overall implementation of Phase 2, the ministry developed a project charter. The charter, dated and approved July 14, 2004, provides the overarching guide to all initiatives being implemented—provincially and regionally. We found that the ministry's provincial implementation plan includes standard project management elements (see sidebar).

We also found that the ministry continues to use the project charter to guide the plan's implementation of both provincial and regional initiatives.

Material included in the provincial project charter includes:

Background section

- Purpose and objectives
- Reasons for change
- Linkage to plan goals/objectives

Change details

- Description of project scope and identification of systems and business process changes required to support phase two of the plan
- Key deliverables, recommended approaches to achieving those deliverables, milestones, resources needed, critical success factors, assumptions, and budget considerations

Monitoring and control

- Sign-off requirements for key elements associated with phase 2
- Project organization, resources, roles and responsibilities
- Key risks to successful implementation and mitigation strategies
- Progress monitoring and reporting requirements
- Change control requirements
- Issues management processes
- Stakeholders and communication requirements

The ministry uses approved plans and adequate monitoring processes to guide regional initiatives implementation

To ensure that regional initiatives are adequately planned and monitored, the ministry established several controls:

- Regional Transition Managers were hired in each region. They are responsible for developing regional charters and annual strategic and implementation plans for approval by the respective Regional Executive Director, the Executive Director, Child and Youth Mental Health, and the Assistant Deputy Minister, Provincial Services and Policy. Regional Transition Managers are also responsible for coordinating the regional implementation of the approved plans, within the approved budgets.
- The Executive Director, Child and Youth Mental Health annually provides a regional planning guide to each region to assist it with developing regional annual implementation plans and developing and updating regional strategic plans.
- The plan includes a clear process for how changes to regional project implementation plans should be made. All material changes to project implementation deliverables, timelines, performance targets and tracking measures must be reviewed by the Executive Director, Child and Youth Mental Health and approved by the Assistant Deputy Minister (executive sponsor) responsible for the plan.
- The plan also defines regional project implementation reporting requirements. Monthly regional status reports are prepared by the Regional Transition Managers in cooperation with the project team, for review and approval by the Regional Executive Director and then by the Executive Director, Child and Youth Mental Health and the Executive Sponsor. The Regional Transition Managers also meet regularly with the Executive Director, Child and Youth Mental Health and with their regional teams to provide updates and resolve issues. The Regional Executive Director receives periodic updates from the Executive Director, Child and Youth Mental Health or Executive Sponsor.

Regional planning guides:

- provide relevant background information;
- re-emphasize the plan's priorities, goals, and guiding principles;
- stipulate the budget allocation that regional plans must conform to;
- set out the content requirements of regional plans;
- outline the provincial priorities for the year under consideration; and
- describe the accountability requirements to be included in regional plans, such as:
  - a statement of key regional priorities/objectives for the year;
  - a regional summary that identifies and details new direct and contracted services by community, and that provide a regional synopsis of enhancements aggregated across communities;
  - a plan for monitoring progress in achieving regional implementation objectives;
  - evaluation strategies for new service models that measure important outcomes;
  - communication plans; and
  - regional milestones that identify target dates for initiatives implemented during the year.

We heard from interviewees that they considered the above processes to be generally well managed. The less favourable comments mainly related to the restrictions placed on how regions could use plan-related funds and the extensive amount of change occurring over a relatively short time period.

Overall, the ministry's provincial initiatives are being adequately managed, but improvements in some areas are needed

Some plan initiatives are being implemented province-wide and managed centrally by the Provincial Services and Policy group. These include:

- the large increase in new clinical staff;
- training of all clinical staff in evidence-based therapies;
- implementation of the FRIENDS program in elementary schools;
- implementation of the BCFPI client screening tool; and
- implementation of the Community and Residential Information System (CARIS) client database.

We discuss each of these initiatives below and the adequacy with which the ministry has been managing them.

Clinical staffing recruitment initiative

The plan noted significant gaps between the need for services and the ministry's ability to provide them. Accordingly, a priority was to increase clinical staff in all regions so that a basic level and range of core services would be available when and where they are needed.

The ministry used a number of administrative tools to plan and monitor the staff recruitment initiative, including:

- a project charter identifying items in and out of scope, risks and mitigation strategies, a process flowchart and timelines;
- a recruitment summary report on FTEs filled and vacant by location;
- guidance for culturally sensitive hiring;
- lessons learned to assist in future recruitment;
- charts of issues and logistics of the recruitment process; and
- a work chart with key deliverables and end dates.

We found that Child and Youth Mental Health regional operations staff endorse the need to increase staff numbers and think that the clinical staffing initiative has been challenging but mostly well done. The most significant criticism was insufficient consideration of regional capacity to support the large recruitment effort. Lack of adequate supervision and delays in completing probationary reviews and performance appraisals were two examples raised.

Staff in Provincial Services and Policy, which is coordinating implementation of the plan, were aware of the above concerns and have been responding to them. Providing clinical supervision training in the fall of 2006 was one step to address the problems. They also completed post-reviews of recruitment drives and documented the key themes to aid in future efforts.

The ministry told us that increased clinical staffing has contributed to improvements since 2004/05 in most of the seven core areas it uses to define "treatment and support services." Those services are:

- consultation,
- community-based assessment and treatment,

- home-based outreach,
- family development services,
- day treatment,
- crisis intervention and stabilization, and
- residential services.

The ministry estimates that during fiscal 2006/07 it provided services to about 20,000 clients as compared with 11,000 at the start of the plan implementation. The ministry estimates it will have spent about $31 million by March 31, 2008 to increase clinical staffing.

Training initiatives

The research underpinning the plan's development stressed the importance of evidence-based treatments. Recommended practices should change as research provides new evidence about the most effective approaches to treating the variety of children's mental health problems and disorders. For this reason, the plan identifies as a priority the need for a training program to ensure that clinicians are kept informed of, and skilled in, evidence-based treatment approaches.

The ministry is using several tools to plan and monitor the evidence-based therapies training initiative: a general training plan and guidance; an updated training schedule and delivery details; and feedback collected after each training session to inform the next one.

The ministry has provided more than 50 training events for clinicians, focusing on evidence-based practices. Clinical staff told us they were satisfied overall with the training, but felt that aspects could have been managed better.

- Some staff, for example, were exhausted by the amount of training they received in such a short time period.
- Some staff had concerns that the time taken for all the training made them less available to work with their clients (though an ongoing training schedule over several years has improved the situation).

- Some contract staff felt left out of the training opportunities that the ministry was initially providing to its own staff (however, Provincial Services and Policy recognized the concern and began offering training to contract staff).
- Some staff think that two days of training on cognitive behavioural therapy is not enough to enable staff to effectively put it into practice.

We also noted that staff sign-up for training in the Vancouver area has been limited. The reason, we learned, is that Child and Youth Mental Health services in the Vancouver area are provided by the Vancouver Coastal Health Authority and not by the ministry. This meant that staff availability for training did not always coincide with the ministry's training dates.

Some staff think that the evidence-based therapy approaches do not work well with very young children or marginalized children (for example, those who are not capable of understanding the concepts, are not part of a family, do not live at home, or do not attend school). The ministry and researchers are aware of these views.

As we discussed earlier, the ministry has been providing clinical staff with evidence-based practice "parameters" to ensure they have the best available information on an ongoing basis. During our fieldwork, however, staff rarely raised the topic of practice parameters. We concluded that staff accept the merit of the initiative, but have difficulty finding the time to read the information and integrate the concepts into practice.

We think that appropriate supervision would help ensure that mental health clinical staff are appropriately applying the training concepts and practice parameters associated with evidence-based therapies. The ministry has recognized the need for this across the province and has been providing training to address the deficiency. Staff told us they support the supervision training, but also commented that it would have been more effective provided earlier in the plan's implementation. They noted as well that the time taken for all the hiring and training has hampered the ability of clinical supervisors to develop a supervision process and apply the training. This has delayed adoption of the concepts. The decision to add Associate Team Leaders in some locations is seen as helping to alleviate this concern.

The ministry estimates it will have spent about $2 million on training initiatives by March 31, 2008.

We recommend that the ministry ensure that all clinicians receive core, evidence-based practices training, that clinical supervisors consistently review staff application of the concepts, and that evidence-based practice parameters be integrated into services.

The FRIENDS program initiative

Implementing the elementary school based FRIENDS program (discussed earlier) has involved efforts to train as many school professionals as possible in delivering the program. The ultimate goal is to provide all British Columbia children in grades 4 and 5 with life skills that will help them cope with worries and stress, and to reduce the risk of them developing an anxiety disorder.

We found that the ministry has used adequate administrative tools to plan and monitor its implementation of FRIENDS. A signed and approved project charter is in place to guide implementation, and it includes the standard project management elements we expect to be present. Most of the school representatives we interviewed were complimentary about the FRIENDS initiative and the ministry's willingness to listen and respond to their critiques and suggestions for improvement.

Uptake of FRIENDS has been strong in the rural/remote areas of the province, but more limited in urban areas such as Vancouver and Victoria. Several clinical staff and school representatives suggested that having school-based champions (one at the executive level and one at the counsellor/teacher level) would improve the program's acceptance in all regions, but particularly in the large urban areas.

A key reason for the success of FRIENDS in regions using it is that the material is provided free of charge by the ministry (the schools' contribution is teacher time to take the training). Some school representatives told us that if they have to pay for the material, or if the cost of teachers on call (to replace teachers being trained) goes up, the program is at risk of losing support. We think that the ministry needs to plan for these risks to ensure the ongoing success of the program.

We also found that the ministry needs more reliable information about the penetration of the FRIENDS program throughout the province. The ministry currently estimates the number of students exposed to the program based on the number of copies of the booklets that have been sent to schools. In our view, there is no assurance that schools receiving the FRIENDS material have actually used it, and we found a few instances where this was the case.

The ministry estimates it will have spent about $1.25 million on the FRIENDS program by March 31, 2008 including the cost of materials and teacher training sessions.

We recommend that the ministry:

- **develop school-based FRIENDS champions in under-represented regions;**
- **develop strategies to mitigate key initiative risks; and**
- **establish mechanisms to monitor penetration of the program throughout the province.**

Courtesy of Ministry of Children and Family Development

New systems are being implemented to help improve mental health services and outcomes

Is the ministry adequately implementing its key initiatives?

The Brief Child and Family Phone Interview (BCFPI) initiative

We found that the ministry has used adequate administrative tools to plan and monitor the implementation of BCFPI. A signed and approved project charter is in place to guide implementation, and it includes the standard project management elements we expect to be present.

However, as we noted before, many staff have still not accepted the usefulness and validity of the tool, citing concerns that range from the length of time it takes to use it, to questions about its effectiveness as a screening tool and treatment guide. The ministry estimates it will have spent $0.8 million on BCFPI by March 31, 2008.

We recommend that the ministry take steps to increase staff acceptance of the Brief Child and Family Phone Interview clinical intake screening tool.

The Community and Residential Information System (CARIS) initiative

CARIS, a computerized case management tool (discussed earlier), is currently in the implementation stage. When fully implemented, the system is expected to provide case management software to four ministry programs:

- Provincial Services for the Deaf and Hard of Hearing,
- Youth Forensic Psychiatric Service,
- Maples Adolescent Treatment Centre, and
- Child and Youth Mental Health Services.

We found that the ministry has been using adequate administrative tools to plan and monitor the development and implementation of CARIS. A signed and approved project charter is in place to guide development, and it includes the standard project management elements we expect to be present. Nevertheless, implementation of the system has been significantly delayed. The original target date to begin was October 2004. The actual date was in February 2006. The ministry identified several difficulties in accounting for this delay, among them:

- unrealistic expectations,
- many components being left for later definition during the project,

- work being done sequentially and not in parallel, and
- a variety of technical problems.

On the positive side, emphasis has been put on quality and completeness and those involved see CARIS as a high quality system. Its implementation has now been completed at Provincial Services for the Deaf and Hard of Hearing and partially completed at the Youth Forensic Psychiatric Service and Maples Adolescent Treatment Centre. Implementation recently started at CYMH Services. The ministry reports that, to date, feedback from staff has been positive.

The ministry estimates it will have spent $3.3 million on CARIS by March 31, 2008.

Is the ministry providing adequate accountability information about the plan's implementation?

The Office of the Auditor General encourages government organizations to provide regular accountability information about their programs to the Legislative Assembly and the public. Because the Child and Youth Mental Health Plan has significantly raised the expectations of stakeholders, this makes public reporting on it especially important so those stakeholders—as well as legislators and the public—can learn about the plan and what has been accomplished to date.

We expected the ministry to:

- be providing adequate information to the Legislative Assembly and public about progress being made in implementing the plan; and
- have an accountability framework in place for gathering information on the extent to which plan objectives have been achieved.

We concluded that the ministry has not been providing adequate accountability information about the plan's implementation. The ministry needs to provide regular information to the Legislative Assembly and public on its progress implementing the plan to date. Also, needed is an accountability framework for reporting on the outcomes achieved.

Accountability reporting on the plan's implementation has been inadequate

The plan states that the Children's Mental Health Network, with members from various stakeholder jurisdictions, will report to the Minister of Children and Family Development and Minister of Health, producing an annual public report on the province's progress toward implementation of the plan.

We found that the ministry's annual service plan report provides some limited activity information related to the plan's implementation and the ministry's website also provides general information about the plan and some of the initiatives being implemented. As well, in September 2006, the ministry prepared a report for Treasury Board in support of the final year of plan funding. That report provides a good overview of the activities that have taken place to implement the plan but it is not publicly available. Overall, we concluded that the ministry has not been

Is the ministry providing adequate accountability information about the plan's implementation?

providing adequate accountability information about the plan's implementation.

We recommend that the ministry report to the Legislative Assembly and the public on the plan's implementation.

The ministry lacks an approved accountability framework for reporting on the outcomes achieved

As described earlier, the plan aims to improve the mental health outcomes of children by:

- expanding the quality and quantity of treatment and support services;
- reducing risk factors in children and families, strengthening resilience, and enhancing protective factors;
- building individual, family and community capacity; and
- improving service system performance and accountability.

The plan calls for the periodic measuring and reporting of performance to the Legislative Assembly and public and, to that end, provides a tentative accountability framework and examples of possible performance objectives and measures associated with the above strategies. The ministry anticipated that the objectives and measures would be further developed and modified as more detailed implementation planning occurred. The information management system improvements described earlier (i.e., BCFPI and CARIS) were expected to supply the information needed to evaluate the success of the plan. However, the framework did not provide measurable targets other than stating that, once fully implemented, the plan investments would result in the following:

- a doubling in the number of mentally ill children and their families being helped each year to overcome the tragic effects of serious mental disorders; and
- an additional 20,000 children with, or at risk of developing, mental disorders being provided treatment and supports annually.

The lack of an approved accountability framework including objectives, measurable targets and a means to gather the information will make it difficult to evaluate the extent to which the plan goals have been met. The report prepared by the ministry

Is the ministry providing adequate accountability information about the plan's implementation?

in September 2006 for Treasury Board (discussed earlier) outlines a new accountability structure, but the information is limited primarily to plan activities rather than patient outcomes.

We recommend that the ministry develop an approved accountability framework capable of evaluating the plan's impact on patient outcomes.

Ministry Response

Ministry of Children and Family Development's Response to the Report of the Auditor General on the Child and Youth Mental Health Plan

General Response

The Ministry of Children and Family Development (MCFD) is pleased to provide a formal response to the Office of the Auditor General's review entitled "The Child and Youth Mental Health Plan: A Promising Start to Meeting an Urgent Need."

On a broad level MCFD sees the report as positive, factually accurate and supportive of the directions the Province of British Columbia has taken in improving the mental health outcomes of children and youth.

MCFD is committed to continuing efforts to improve the mental health outcomes of children and youth in British Columbia. Improving the mental health outcomes for Aboriginal children and youth is of particular concern. As acknowledged in this report, on behalf of the Province, MCFD has taken many steps to improve child and youth mental health outcomes through more timely and effective treatment and support services; programs to reduce the risk of, and mitigate the effects of, mental disorders; new efforts to improve the capacities of families and communities to prevent or overcome the harmful impact of mental disorders in children and youth; and better systems to coordinate services, monitor outcomes, and ensure public accountability for policies and programs.

The Key Findings section clearly shows that the efforts have been worthwhile. The Auditor General notes the following:

- *the ministry's Child and Youth Mental Health Plan is an adequate plan for improving the mental health outcomes of children and youth;*
- *the ministry is adequately ensuring that its key initiatives are consistent with the plan goals and appropriately supported; and*
- *the ministry is adequately planning and monitoring initiative implementation, but that improvements can be made.*

These findings by the Office of the Auditor General are a substantial endorsement of the Plan that the Province has implemented to ensure improved outcomes for children and youth with or at risk of developing mental health problems.

Ministry Response

Responses to Specific Recommendations

The Office of the Auditor General provided a number of specific, and generally technical, recommendations which the Ministry will use as a guide to improving certain aspects of the implementation of the Child and Youth Mental Health Plan. The responses and comments of the Ministry to the recommendations follow.

Recommendations regarding the adequacy of the Child and Youth Mental Health Plan

Recommendation 1: **The ministry should ensure that clinical staff clearly understands the ministry's policy on treating patients with both a mental disorder and a developmental or learning disorder to ensure a consistent approach across the province.**

Actions taken to date: *The ministry's Expert Table on Dual Diagnosis (mental and developmental disorders) has recommended providing training to better equip CYMH staff to work with children and youth who struggle with co-occurring mental illness and disabilities and their families, and to improve collaboration with other professionals. This training will contribute to clearer policy direction about providing services to this population and will also build capacity to do so. Curriculum is currently under development.*

Actions planned: *Training in the area of dual diagnosis is planned for Spring of 2008.*

Recommendation 2: **As the ministry finalizes its organizational changes, it should:**

- **ensure that adequate accountability mechanisms continue to exist between the ministry's regional operations and the provincial office so that plan objectives remain a priority, at least during the final year of implementation;**

Actions taken to date: *Each region submits a monthly status reports in any circumstance when the region has made a decision to vary or change the approved CYMH plan. Currently these reports are reviewed by both the CYMH policy area and the Regional Support Secretariat.*

Actions planned (including timeframes): *The ministry is currently developing a Quality Assurance Framework which will be presented to the MCFD Leadership Team by the end of June 2007. Specific outcomes for children and youth receiving mental health services will be included.*

- **ensure that there continues to be strong ministry leadership for child and youth mental health services;**

Actions taken to date: *There will continue to be strong leadership for CYMH provincially and regionally. Though there may be structural differences between regions, each region has identified continued CYMH leadership as a priority. The hiring of additional CYMH Team Leaders as part of implementation of the CYMH Plan has increased leadership at the community level.*

Actions planned (including timeframes): *No further action is planned.*

- **address stakeholder concerns about the reorganization;**

Actions taken to date: *Many key CYMH stakeholders are members of the CYMH Network, which continues to meet three times per year. The Network has provided a forum for these stakeholder representatives to air concerns and develop solutions. In many regions, regional CYMH Networks have provided a similar function.*

Actions planned (including timeframes): *No further actions planned.*

- **and begin formulating new strategies that will build on the accomplishments achieved under the province's first Child and Youth Mental Plan.**

Actions taken to date: *The CYMH Network and the External Advisory Committee on Child and Youth Mental Health continue to meet regularly.*

Actions planned (including timeframes): *By the end of 2008, MCFD will conduct a systemic review of services for children and youth with, or at risk of developing, mental illness that examines accomplishments, progress to date, gaps in service, and next steps. New strategies will continue to be developed as MCFD continues to improve and integrate services.*

Ministry Response

Recommendations regarding the choice of initiatives to implement the Child and Youth Mental Health Plan

Recommendation 3: **The ministry should develop a clear strategy to bring about meaningful inter-sectoral collaboration, particularly with physicians.**

Actions taken to date: *Inter-sectoral collaboration across government ministries and offices is achieved through the Child and Youth Mental Health Network. Collaboration with physicians specifically has occurred in relation to individual projects such as the dissemination of self-help and other resources through the College of Family Physicians of BC, physician input on expert advisory tables, and Ministry participation in a BCMA/government committee to develop clinical practice guidelines for general practitioners. At the outset of the Child and Youth Mental Health Plan, more active involvement of the medical community was envisioned as a means of fostering linkages between primary health care and community-based child and youth mental health services. Ongoing engagement of professional medical organizations has proven very challenging, in part because most of the physician initiatives and incentives to improve mental health care in general practice are initiated and coordinated through the Ministry of Health. As yet, there is no formal channel for MCFD to collaborate in these endeavours.*

Actions planned: *Senior executives from MCFD will continue to reinforce the importance of inclusion of CYMH in primary heath care initiatives that influence how physicians practice in relation to children with mental illness and their families. In particular, effort will be made to ensure a focus on children's mental health is part of a new proposed physician fee incentive to encourage improved mental health care planning.*

Recommendations regarding the implementation of its key Child and Youth Mental Health Plan initiatives

Recommendation 4: **To improve implementation of the initiatives, we recommend that the ministry:**

- **ensure that all clinicians receive core, evidence-based practices training, that clinical supervisors consistently review staff application of the concepts, and that evidence-based practice parameters be integrated into services;**

Actions taken to date: *To date, over two-thirds of clinicians have taken at least one evidence-based clinical training course since inception of the CYMH Plan; one quarter of clinicians have taken two or more of the four core training components.*

A plan for continued training in fiscal year 2007/08 has been developed in conjunction with CYMH regional transition managers.

To reinforce application of new evidence-based principles in practice, three training sessions on supervision skills were held for clinical supervisors in the fall 2006 and will be repeated in Fall of 2007.

Actions planned: *A policy is currently under development that establishes evidence-based training as the standard in CYMH and that identifies training that is considered "core".*

A gap analysis will be carried out by April 2008 to determine additional needs for core training. On the basis of this analysis, a training plan for 2008/09 will be prepared to address the additional evidence-based and other core training requirements. Further, new information systems will permit tracking of rates of evidence-based interventions in clinical practice will be routinely tracked beginning in 2008/09.

- **develop school-based FRIENDS champions in under-represented regions,**

Actions taken to date: *A FRIENDS liaison in each school district has been appointed. In addition to assistance with program communications and coordination of local training events, these individuals help to promote the program with teachers in their district. Given the limited uptake in Greater Victoria school districts, the FRIENDS Consultant/trainer has met with the three CYMH teams in Victoria so that clinicians within these teams may also act as champions for the program and be available to teachers as a local resource. In addition, communication was sent to all BC Superintendents and elementary school principals emphasizing the value of FRIENDS in the classroom and reiterating that FRIENDS addresses Ministry of Education prescribed learning outcomes for social responsibility. It is hoped that these efforts will result in district level commitment to the program.*

Actions planned: *The FRIENDS Consultant/trainer will meet FRIENDS liaison personnel from large urban districts, such as Surrey, Vancouver and Victoria by November 2007 to identify strategies to improve elementary school participation in the program in urban centres for the 2007/08 school year. In schools districts that have mandated*

FRIENDS delivery in all elementary schools, Ministry staff will explore the factors responsible for greater program support and work with other districts to promote factors which facilitate uptake. This will also be completed in fall of the 2007/08 school year.

- **develop strategies to mitigate key risks;**

Actions taken to date: *The FRIENDS program has included funding in the 2007/08 budget to cover costs of all program materials (Leaders Manual and Student Workbooks) for teachers and students. MCFD has covered these costs since the program was launched in 2004 and recognizes that this is a key component to the success of the program.*

Actions planned: *MCFD will continue to cover the costs of all program materials for schools participating in the program. Regarding the risk of an increase in teacher coverage costs, the FRIENDS program will work with each FRIENDS school district liaison to deliver the one-day FRIENDS training during district professional development days, when possible, and offer late afternoon/evening trainings upon request thereby avoiding the need for the district to incur salary replacement costs.*

- **and establish mechanisms to monitor penetration of the program throughout the province;**

Actions taken to date: *To date, program penetration throughout the province has been roughly tracked on the basis of teacher participation in training events and the number of manuals and workbooks ordered by schools. Recognizing the limitations of this, the Ministry, in collaboration with academic research partners and BC Stats, created a program evaluation team to design a valid approach to monitoring program implementation and program impact.*

Actions planned (including timeframes): *By the end of this school year, BC Stats, will conduct a survey of teachers who participated in FRIENDS training to ascertain where the program is being delivered. This implementation mapping exercise will be completed by August 31, 2007.*

- **take steps to increase staff acceptance of the Brief Child and Family Phone Interview clinical intake assessment tool.**

Actions taken to date: *Consistent with best practice, MCFD has established use of the Brief Child and Family Phone Interview (BCFPI) as the standard screening tool for CYMH. The ministry acknowledges there have been some growing pains as practice shifts to incorporate*

use of the BCFPI, and has taken steps to solve immediate problems and establish processes for addressing future ones. Specific measures have included holding a forum, attended by all CYMH Clinical Supervisors, was held in February 2006 to review field experience with the BCFPI and address any emerging issues. Individual consultation with regional staff including intake workers is currently underway. From these consultations, a BCFPI Reference group is being created as a problem solving resource for BCFPI users.

Actions planned: *Consultation with regional staff regarding BCFPI implementation will be completed by September 2007 resulting in recommendations to the Ministry.*

BCFPI Aggregate Reports are currently under development. Access to these reports will substantially improve the ability to understand current CYMH usage and to plan future services at the local, regional and provincial level. These reports will be available July 2007.

Recommendations regarding accountability information related to the Child and Youth Mental Health Plan

Recommendation 5: **To improve accountability for the Child and Youth Mental Health Plan, we recommend that the ministry:**

- **report to the Legislative Assembly and the public on the plan's implementation progress;**

Actions taken to date: *A report on implementation of the CYMH Plan was submitted to Treasury Board in September 2006. This report was prepared after only one full year of base funding and hence does not provide a complete assessment of implementation progress.*

Actions planned: *At this time, there has been no request for the Ministry to submit an implementation progress report to the Legislative Assembly. A summary report for external stakeholders and the public based on the report to Treasury Board is underway and will communicate progress in relation of key CYMH Plan strategies. The report is expected to be completed by October 1, 2007.*

Ministry Response

- **develop an approved accountability framework capable of evaluating the plan's impact on the outcomes of children and youth with or at risk of developing mental illness.**

Actions taken to date: *An accountability framework for the Child and Youth Mental Health Plan, developed in the form of a program logic model, was approved by the Assistant Deputy Minister, Provincial Services, in February 2006. The framework identifies key implementation strategies, expected outputs and outcomes. Intended outcomes are specified at both the client and system level.*

Actions planned: *Client outcome data can be generated once the Brief Child and Family Phone Interview (BCFPI) and the Community and Residential Information System (CARIS) are fully implemented. These administrative systems will provide information on clients' clinical and functional status at intake and discharge and thus yield treatment outcome data for children served through community-based child and youth mental health services.*

In addition to reporting on outcomes for children and families who are recipients of CYMH services, population level mental health status information will be acquired and reported annually through a monitoring project led by the Children's Health Policy Centre at Simon Fraser University.

Lesley duToit *June 11, 2007*
Deputy Minister
Ministry of Children and Family Development

Appendices

Appendix A: Ministry Operated Child and Youth Mental Health Offices

Region	Office Name	City	Clinician FTE's *(Note 1)*
Fraser	CYMH Abbotsford	Abbotsford	21.14
	CYMH Fraser East Aboriginal Team	Abbotsford	2.98
	CYMH Agassiz - Harrison	Agassiz	—
	CYMH Burnaby	Burnaby	7.87
	CYMH Burnaby Brentwood	Burnaby	—
	CYMH Burnaby Early Childhood	Burnaby	7.00
	CYMH Chilliwack	Chilliwack	5.12
	CYMH Simon Fraser Youth Day Treatment	Coquitlam	5.00
	CYMH Delta-South	Delta	—
	CYMH Fraser South Eating Disorders	Delta	—
	CYMH Hope	Hope	3.65
	CYMH Langley	Langley	10.70
	CYMH Ridge Meadows	Maple Ridge	4.55
	CYMH Mission	Mission	2.54
	CYMH New Westminster	New Westminster	3.62
	CYMH Fraser North Eating Disorders	Port Moody	—
	CYMH Tri-Cities	Port Moody	12.35
	CYMH Tri-Cities SDC	Port Moody	—
	CYMH Delta-North	Surrey	6.50
	CYMH Fraser West Aboriginal Team	Surrey	3.00
	CYMH Surrey Guildford	Surrey	7.74
	CYMH Surrey Newton	Surrey	12.52
	CYMH Surrey North	Surrey	7.69
	CYMH Surrey Outreach Team	Surrey	5.00
	CYMH White Rock South Surrey	Surrey	3.80
Fraser: 25 Ministry CYMH Service Locations			**132.77**

Appendix A: Ministry Operated Child and Youth Mental Health Offices

Region	Office Name	City	Clinician FTE's *(Note 1)*
Interior	CYMH 100 Mile House	100 Mile House	4.00
	CYMH Ashcroft	Ashcroft	—
	CYMH Castlegar	Castlegar	—
	CYMH Chase	Chase	—
	CYMH Clearwater	Clearwater	—
	CYMH Cranbrook	Cranbrook	6.58
	CYMH Fernie	Fernie	—
	CYMH Golden	Golden	1.00
	CYMH Grand Forks	Grand Forks	1.00
	CYMH Invermere	Invermere	—
	CYMH Kamloops	Kamloops	12.75
	CYMH Kelowna	Kelowna	19.60
	CYMH Keremeos	Keremeos	—
	CYMH Lillooet	Lillooet	0.86
	CYMH Merritt	Merritt	2.00
	CYMH Nelson	Nelson	6.72
	CYMH Osoyoos	Osoyoos	—
	CYMH Penticton	Penticton	7.97
	CYMH Princeton	Princeton	—
	CYMH Revelstoke	Revelstoke	1.00
	CYMH Salmon Arm	Salmon Arm	3.55
	CYMH Summerland	Summerland	—
	CYMH Trail	Trail	—
	CYMH Vernon	Vernon	5.65
	CYMH Williams Lake	Williams Lake	3.20
Interior: 25 Ministry CYMH Service Locations			**75.88**
North	CYMH Chetwynd	Chetwynd	1.00
	CYMH Dawson Creek	Dawson Creek	4.59
	CYMH Fort Nelson	Fort Nelson	—
	CYMH Fort St. John	Fort St. John	2.00
	CYMH Hazelton	Hazelton	—
	CYMH Houston	Houston	—
	CYMH Kitimat	Kitimat	2.00
	CYMH Prince George	Prince George	2.94
	CYMH Prince Rupert	Prince Rupert	5.00
	CYMH Queen Charlotte Islands	Queen Charlotte	1.00
	CYMH Quesnel	Quesnel	2.49
	CYMH Smithers	Smithers	6.00
	CYMH Terrace	Terrace	4.30
North: 13 Ministry CYMH Service Locations			**31.32**

Appendix A: Ministry Operated Child and Youth Mental Health Offices

Region	Office Name	City	Clinician FTE's *(Note 1)*
Vancouver Coastal	CYMH Bella Coola	Bella Coola	—
	CYMH Gibsons	Gibsons	5.22
	CYMH North Shore	North Vancouver	6.26
	CYMH Pemberton	Pemberton	—
	CYMH Sechelt	Sechelt	—
	CYMH Squamish	Squamish	5.78
Vancouver Coastal: 6 Ministry CYMH Service Locations			**17.26**
Vancouver Island	CYMH Campbell River	Campbell River	5.59
	CYMH Courtenay	Courtenay	6.14
	CYMH Duncan	Duncan	6.72
	CYMH Central Island Aboriginal Team	Nanaimo	1.00
	CYMH Nanaimo	Nanaimo	8.50
	CYMH Parksville	Parksville	3.88
	CYMH Port Alberni	Port Alberni	3.90
	CYMH Port Hardy	Port Hardy	1.00
	CYMH Saanich	Victoria	7.87
	CYMH South Island Aboriginal Team	Victoria	1.00
	CYMH South Island Eating Disorders	Victoria	5.99
	CYMH South Island High Risk	Victoria	4.70
	CYMH Victoria	Victoria	8.27
	CYMH West Shore	Victoria	7.36
Vancouver Island: 14 Ministry CYMH Service Locations			**71.92**
British Columbia: 83 Ministry CYMH Service Locations			**329.15**

Note 1: FTE stands for "fulltime equivalent" and is defined as the employment of one person for one full year or equivalent thereof. For offices with no FTEs shown, clinician costs are being paid for by one of the other offices.

Appendix B: Contracted Child and Youth Mental Health Offices

These offices are operated by contracted agencies that provide services under the ministry's direction.

Region	City	Number of Agencies
Fraser	Abbotsford	3
	Agassiz	1
	Burnaby	2
	Chilliwack	1
	Coquitlam	2
	Delta	3
	Hope	1
	Langley	1
	Maple Ridge	2
	Mission	1
	New Westminster	5
	Surrey	4
	White Rock	1
Fraser Total		**27**
Interior	Castlegar	2
	Clearwater	1
	Cranbrook	3
	Creston	1
	Fernie	1
	Golden	1
	Grand Forks	1
	Invermere	1
	Kamloops	4
	Kaslo	1
	Kelowna	4
	Keremeos	1
	Lillooet	1
	Merritt	1
	Nakusp	1
	Nelson	2
	Penticton	2
	Salmo	1
	Salmon Arm	1

Appendix B: Contracted Child and Youth Mental Health Offices

Region	City	Number of Agencies
Interior (cont'd)	Slocan	1
	Trail	1
	Vernon	4
	Westbank	1
	Williams Lake	3
Interior Total		**40**
North	Burns Lake	2
	Dawson Creek	2
	Fort St. James	1
	Fort St. John	1
	Kitimat	1
	Mackenzie	1
	McBride	1
	Moberly Lake	1
	New Aiyansh	1
	Prince Rupert	1
	Prince George	7
	Prince Rupert	1
	Quesnel	1
	Smithers	2
	Terrace	1
	Thornhill	1
	Vanderhoof	1
North Total		**26**
Vancouver Coastal	Bella Coola	1
	North Vancouver	2
	Powell River	1
	Sechelt	1
	Squamish	1
	Vancouver	3
	Whistler	1
Vancouver Coastal Total		**10**

Appendix B: Contracted Child and Youth Mental Health Offices

Region	City	Number of Agencies
Vancouver Island	Campbell River	2
	Courtenay	2
	Duncan	1
	Lake Cowichan	1
	Nanaimo	5
	Port Alberni	5
	Port Hardy	2
	Port Renfrew	1
	Qualicum Beach	1
	Salt Spring Island	1
	Victoria	5
Vancouver Island Total		**26**
Total Agencies		**129**

Appendix C: Ministry Equivalent Child and Youth Mental Health Offices

(These offices are operated by contracted agencies that are equivalent to ministry offices)

Region	Office Name	City	Number of Clinicians
North	Prince George Youth & Family Services Society	Prince George	19
North Total			**19**
Vancouver Coastal	Powell River Child Youth & Family Services Society	Powell River	5
	North Shore VCHA Youth/Family Program	North Vancouver	1
	North Shore VCHA Child/Youth Program	North Vancouver	3
	Richmond VCHA Child & Adolescent Program	Richmond	7
	Richmond VCHA School Program	Richmond	3
	Vancouver VCHA Adolescent Outreach	Vancouver	2
	Vancouver VCHA Alan Cashmore	Vancouver	6
	Vancouver VCHA Child & Adolescent Response Team	Vancouver	4
	Vancouver VCHA Community Link Program	Vancouver	1
	Vancouver VCHA Connect Parent Group	Vancouver	2
	Vancouver VCHA Dual Diagnosis	Vancouver	2
	Vancouver VCHA Early Psychosis Intervention	Vancouver	3
	Vancouver VCHA Gastown Vocational Services	Vancouver	3
	Vancouver VCHA Grandview/Woodland	Vancouver	3
	Vancouver VCHA Hamber House	Vancouver	4
	Vancouver VCHA Intake	Vancouver	7
	Vancouver VCHA Kitsilano-Vancouver	Vancouver	3
	Vancouver VCHA Midtown Vancouver	Vancouver	4
	Vancouver VCHA Northeast Vancouver	Vancouver	5
	Vancouver VCHA Parent AD/HD	Vancouver	3
	Vancouver VCHA SAFER	Vancouver	2
	Vancouver VCHA South	Vancouver	5
	Vancouver VCHA Strathcona	Vancouver	2
	Vancouver VCHA Well Being Program	Vancouver	3
	Vancouver VCHA West End	Vancouver	3
	Vancouver VCHA West Side	Vancouver	4
	Vancouver VCHA Youth Res	Vancouver	4
	Vancouver VCHA Youth SIL	Vancouver	1
Vancouver Coastal Total			**95**
British Columbia: 29 Ministry-equivalent CYMH Locations			**114**

Appendix D: Regional Risk Reduction Activities

Interior Region

- Suicide Awareness Day events were held during fall 2006. Screening and assessment tools have been established as well as a suicide intervention training program.
- Contracts for new programs in three of five "Aboriginal zones," aimed at increasing the coping skills of Aboriginal children and youth, were expected to be operational in fall 2006. In the two remaining zones, the Aboriginal Suicide Community Response Intervention Teams are to be developed.
- Plans are underway to incorporate a Mental Health Tool Kit across services in the Interior office of the Ministry of Children and Family Development, with the aim of increasing awareness of mental disorder signs, symptoms and mechanisms for intervention/referral.
- Early psychosis intervention programs, co-led and co-funded by the Interior Health Authority and the ministry, are to be established within the Interior.

Fraser Region

- Specialized infant mental health services are now provided in more than half of the region's communities.
- The hiring of Aboriginal outreach workers has begun.
- Kids in Control groups, for children of parents with mental disorders, now exist in most communities in the Fraser region. The "Supporting Families with Parental Illness" initiative is producing planning agreements and written protocols between service providers to support families.
- Shared mental health care, to provide early intervention services for children with mental health problems, have been established in family physician offices in New Westminster and Tri-Cities.
- Three Early Psychosis Intervention "hubs" have been established to provide rapid specialized assessment and stabilization before formal service is received from Ministry of Children and Family Development clinicians in local communities.

Appendix D: Regional Risk Reduction Activities

Vancouver Coastal Region

- The Strengthening Families Program, an evidence-based parenting program, has been implemented in Squamish and Powell River.
- The Aboriginal Strengthening Families Program, delivered by Aboriginal facilitators to Aboriginal families, has begun in Vancouver and Mt. Currie.
- Communities that Care has been established in partnership with the Squamish municipality and Vancouver Coastal Health Authority. The program supports community action plans to address underlying risk factors related to mental disorders, substance abuse and domestic violence.
- A Behavioural Prevention Worker has been hired to work in schools, providing information, skill development and consultation to school staff.
- The Parent Group Program, an education and skills group for parents of pre-adolescents who are at risk of developing conduct disorder, was first piloted in Vancouver and is now established as an ongoing program. The intent is to expand it to other communities across the region.
- The Youth Theatre Project is a live theatre production on mental health issues, designed by youth and delivered in high schools across Vancouver in partnership with addiction services.
- Infant mental health prevention and early intervention services are available in Gibsons and Sechelt.

Vancouver Island Region

- Vancouver Island provided pilot funding for one year to the Nuu-chah-nulth Tribal Council to provide a range of mental health services to the Ahousat Nation and neighboring communities that are experiencing a suicide crisis among their youth. Experience from this project will inform broader planning decisions for the Aboriginal services in the region.
- Nanaimo region has implemented the school-based Peer Counseling program focusing on health promotion and prevention,
- An Aboriginal counselor has been appointed to provide early intervention and treatment to 35 youth and families.

Appendix D: Regional Risk Reduction Activities

- A coordinator has been hired to identify and address mental health needs of at-risk youth in Port Renfrew. Services have been provided to 70 youth.

North Region

- After a successful demonstration project of two Aboriginal youth suicide prevention programs (Loomsk Life Skills and Whitestone), implemented by the Tsimshian Tribal Council, both have now been adopted and expanded by School District 52.
- Four Early Intervention Specialist positions (4.0 full-time-equivalents) have been created.
- Incredible Years training with community partners was planned for spring 2007.
- The Parent Connect program was planned for delivery in two communities in fall 2006.

Appendix E: Regional Initiatives to Build Individual, Family and Community Capacity

Interior Region

- Educational information is being provided through The F.O.R.C.E. in the South Okanagan and the East Kootenay areas.
- Co-planning is underway with the Interior Health Authority to jointly develop plans and programs to build community capacity.
- School-based mental health clinicians have been established, with the role of educating school counsellors on mental health disorders and developing parent education groups on how to support a child's mental health.

Fraser Region

- Efforts are underway to increase awareness of mental health and child and youth mental health, especially for multi-cultural communities.
- Various initiatives are underway to foster the active involvement of youth and families.
- With the assistance of The F.O.R.C.E and the Canadian Mental Health Association (Delta and Simon Fraser), self-help support groups for families with children or youth with mental illness are being developed and opportunities for youth involvement and mentoring are being created.
- Outreach early childhood consultation services for multi-cultural populations in Burnaby have been contracted.

Vancouver Coastal Region

- The Parent Support Group is working with The F.O.R.C.E to support ongoing connections between parents of children with mental illness and to develop support/advocacy networks in the Sea-to-Sky and Sunshine Coast communities.
- The Strong Kids Group has been established on the Sunshine Coast. Working in partnership with an independent school, this group provides evidence-based social skills to children 10–12 years of age.
- Richmond is developing a cultural competency plan to increase access and accommodation of child and youth mental health services for Asian families.

Appendix E: Regional Initiatives to Build Individual, Family and Community Capacity

Vancouver Island Region

- Greater emphasis is being placed on family advocacy and community capacity-building activities.
- Several communities have developed a partnership with The F.O.R.C.E. to provide various capacity-building activities.
- Campbell River has established an Aboriginal Child and Youth Mental Health group to help build community capacity.

North Region

- A strategic plan for managing and treating child and youth mental health was completed. It was developed collaboratively by the Northern Aboriginal Authority for Families, the Northern Health Authority and the Ministry of Children and Family Development.
- The Small Community Initiative Program (SCIP) was enhanced to improve access in small communities with limited Child and Youth Mental Health service capacity.
- Three rural coordinators have been hired to assist Aboriginal agencies with capacity building.
- The Strengthening Families pilot project was implemented in fall 2006.

Appendix F: Office of the Auditor General: Performance Auditing Objectives and Methodology

The Office has three lines of business:

- examining the reliability of the provincial public sector's financial reporting;
- assessing how well the public sector manages its key risks; and
- assessing the quality of provincial public sector performance reports.

Each of these lines of business has certain objectives that are expected to be achieved, and each employs a particular methodology to reach those objectives. The following is a brief outline of the objectives and methodology applied by the Office for assessing how well the public sector manages its key risks.

Performance Auditing

What are Performance Audits?

Performance audits (also known as value-for-money audits) examine whether money is being spent wisely by government—whether value is received for the money spent. Specifically, they look at the organizational and program elements of government performance, whether government is achieving something that needs doing at a reasonable cost, and consider whether government managers are:

- making the best use of public funds; and
- adequately accounting for the prudent and effective management of the resources entrusted to them.

The aim of these audits is to provide the Legislature with independent assessments about whether government programs are implemented and administered economically, efficiently and effectively, and whether Members of the Legislative Assembly and the public are being provided with fair, reliable accountability information with respect to organizational and program performance.

Appendix F: Office of the Auditor General: Performance Auditing Objectives and Methodology

In completing these audits, we collect and analyze information about how resources are managed; that is, how they are acquired and how they are used. We also assess whether legislators and the public have been given an adequate explanation of what has-been accomplished with the resources provided to government managers.

Focus of Our Work

A performance audit has been described as:

... the independent, objective assessment of the fairness of management's representations on organizational and program performance, or the assessment of management performance, against criteria, reported to a governing body or others with similar responsibilities.

This definition recognizes that there are two forms of reporting used in performance auditing. The first—referred to as attestation reporting—is the provision of audit opinions as to the fairness of management's publicly reported accountability information on matters of economy, efficiency and effectiveness. This approach has been used to a very limited degree in British Columbia because the organizations we audit do not yet provide comprehensive accountability reports on their organizational and program performance.

We believe that government reporting along with independent audit is the best way of meeting accountability responsibilities. Consequently, we have been encouraging the use of this model in the British Columbia public sector, and will apply it where comprehensive accountability information on performance is made available by management.

As the performance audits conducted in British Columbia use the second form of reporting—direct reporting—the description that follows explains that model.

Our "direct reporting" performance audits are not designed to question whether government policies are appropriate and effective (that is, achieve their intended outcomes). Rather, as directed by the *Auditor General Act*, these audits assess whether the programs implemented to achieve government policies are being administered economically and efficiently. They also evaluate whether Members of the Legislative Assembly and the public are being provided

Appendix F: Office of the Auditor General: Performance Auditing Objectives and Methodology

with appropriate accountability information about government programs.

When undertaking performance audits, we look for information about results to determine whether government organizations and programs actually provide value for money. If they do not, or if we are unable to assess results directly, we then examine management's processes to determine what problems exist or whether the processes are capable of ensuring that value is received for money spent.

Selecting Audits

All of government, including Crown corporations and other government organizations, are included in the universe we consider when selecting audits. We also may undertake reviews of provincial participation in organizations outside of government if they carry on significant government programs and receive substantial provincial funding.

When selecting the audit subjects we will examine, we base our decision on the significance and interest of an area or topic to our primary clients, the Members of the Legislative Assembly and the public. We consider both the significance and risk in our evaluation. We aim to provide fair, independent assessments of the quality of government administration and to identify opportunities to improve the performance of government. Therefore, we do not focus exclusively on areas of high risk or known problems.

We select for audit either programs or functions administered by a specific ministry or government organization, or cross-government programs or functions that apply to many government entities. A large number of such programs and functions exist throughout government. We examine the larger and more significant of these on a cyclical basis.

Our view is that, in the absence of comprehensive accountability information being made available by government, performance audits using the direct reporting approach should be undertaken on a five- to six- year cycle so that Members of the Legislative Assembly and the public receive assessments of all significant government operations over a reasonable time period. We strive to achieve this schedule, but it is affected by the availability of time and resources.

Appendix F: Office of the Auditor General: Performance Auditing Objectives and Methodology

Planning and Conducting Audits

A performance audit comprises four phases — preliminary study, planning, conducting and reporting. The core values of the Office— independence, due care and public trust — are inherent in all aspects of the audit work.

Preliminary Study

Before an audit starts, we undertake a preliminary study to identify issues and gather sufficient information to decide whether an audit is warranted.

At this time, we also determine the audit team. The audit team must be made up of individuals who have the knowledge and competence necessary to carry out the particular audit. In most cases, we use our own professionals, who have training and experience in a variety of fields. As well, we often supplement the knowledge and competence of our staff by engaging one or more consultants to be part of the audit team.

In examining a particular aspect of an organization to audit, auditors can look either at results, to assess whether value for money is actually achieved, or at management's processes, to determine whether those processes should ensure that value is received for money spent. Neither approach alone can answer all the questions of legislators and the public, particularly if problems are found during the audit. We therefore try to combine both approaches wherever we can. However, because acceptable results-oriented information and criteria are often not available, our performance audits frequently concentrate on management's processes for achieving value for money.

If a preliminary study does not lead to an audit, the results of the study may still be reported to the Legislature.

Planning

In the planning phase, the key tasks are to develop audit criteria — "standards of performance" — and an audit plan outlining how the audit team will obtain the information necessary to assess the organization's performance against the criteria. In establishing the criteria, we do not expect theoretical perfection from public sector managers; rather, we reflect what we believe to be the reasonable expectations of legislators and the public.

Appendix F: Office of the Auditor General: Performance Auditing Objectives and Methodology

Conducting

The conducting phase of the audit involves gathering, analyzing and synthesizing information to assess the organization's performance against the audit criteria. We use a variety of techniques to obtain such information, including surveys, and questionnaires, interviews and document reviews.

Reporting Audits

We discuss the draft report with the organization's representatives and consider their comments before the report is formally issued to the Legislative Assembly. In writing the audit report, we ensure that recommendations are significant, practical and specific, but not so specific as to infringe on management's responsibility for managing. The final report is tabled in the Legislative Assembly and referred to the Public Accounts Committee, where it serves as a basis for the Committee's deliberations.

Reports on performance audits are published throughout the year as they are completed, and tabled in the Legislature at the earliest opportunity. We report our audit findings in two parts: an Auditor General's Comments section and a more detailed report. The overall conclusion constitutes the Auditor General's independent assessment of how well the organization has met performance expectations. The more detailed report provides background information and a description of what we found. When appropriate, we also make recommendations as to how the issues identified may be remedied.

It takes time to implement the recommendations that arise from performance audits. Consequently, when management first responds to an audit report, it is often only able to indicate its intention to resolve the matters raised, rather than to describe exactly what it plans to do.

Without further information, however, legislators and the public would not be aware of the nature, extent, and results of management's remedial actions. Therefore, we publish updates of management's responses to the performance audits. In addition, when it is useful to do so, we will conduct follow-up audits. The results of these are also reported to the Legislature.

Appendix G: Office of the Auditor General: 2007/2008 Reports Issued to Date

Report 1 – April 2007

Special Audit Report to the Speaker: The Financial Framework Supporting the Legislative Assembly

Report 2 – June 2007

The Child and Youth Mental Health Plan: A Promising Start to Meeting an Urgent Need

The above reports can be accessed through our website at http://www.bcauditor.com