# Representative for Children and Youth Presentation to the 2022 Social Policy Forum

## Questions & Answers

**Q. Is it working for child and youth mental health to be a separate Ministry from adult mental health or from health care? (Maya Russell, CMHA, she/her)**

**Q. The separation of child/youth mental health from the health system does not make sense when we are working with the severity and complexity that often requires medication and hospitalizations and the biology of how substance use impacts an individual. Is there discussion/consideration of moving CYMH under the health system as opposed to MCFD? (Karen Ausejo, she/her/hers)**

A. You raise a great question. I have been around long enough to see child and youth mental health in several different ministries and I am inclined to think that it is best situated within a health context to reinforce that mental health is a health issue not a failing of the individual or family. I also think it is important that there is continuity between child and adult systems although never losing sight that children have unique developmental needs and that mental health services need to be child centred. Having said that, I worry because the health system too has many challenges and silos can be created anywhere, so the bigger concern for me is not so much where the services are housed/which ministry is responsible but the underpinning values, beliefs, attitudes and scope of practice.

**Q. I think one of the biggest challenges with working with front line youth is the silos in which programs and agencies work. There is a crossover between mental health, addiction, health, and youth justice but everyone takes hands off approach in hopes some other silo will step up. Are there discussions taking place within the concept of the 'four pillars' approach announced recently in how we will work more collaboratively together? (Devon Murray, she/her)**

A. Devon, you have named one of the greatest worries that we have in the RCY about the care that young people receive. Service providers often want to collaborate but there are structural and systemic barriers to doing so (e.g. contract language that restricts agencies from engaging in collaborative practice; restraints on information sharing) and this is coupled with a sense that the silo we are in as a practitioner doesn't have much to offer so we hope someone else will pick it up. If you could clarify which 'four pillars approach you are referring to that would be helpful (there are a few frameworks under development). I

think that there is a recognition that we need to collaborate but lack of clarity about how to do it.

**Q. When you speak about young children being placed into residential homes created for them due to their high needs (which I can totally relate to as a Senior Manager at IDM Youth Services, a provider of these homes) which are essential group homes without the group—such a powerful way to put this—what do you see as the solution to this or a way to avoid this? You mentioned offering support earlier, do you have any other suggestions? (Bronwyn Balderson)**

A. Thanks for the question. This is really complex (hence the pattern of complexity I shared). But based on what we see, there are a few possibilities:

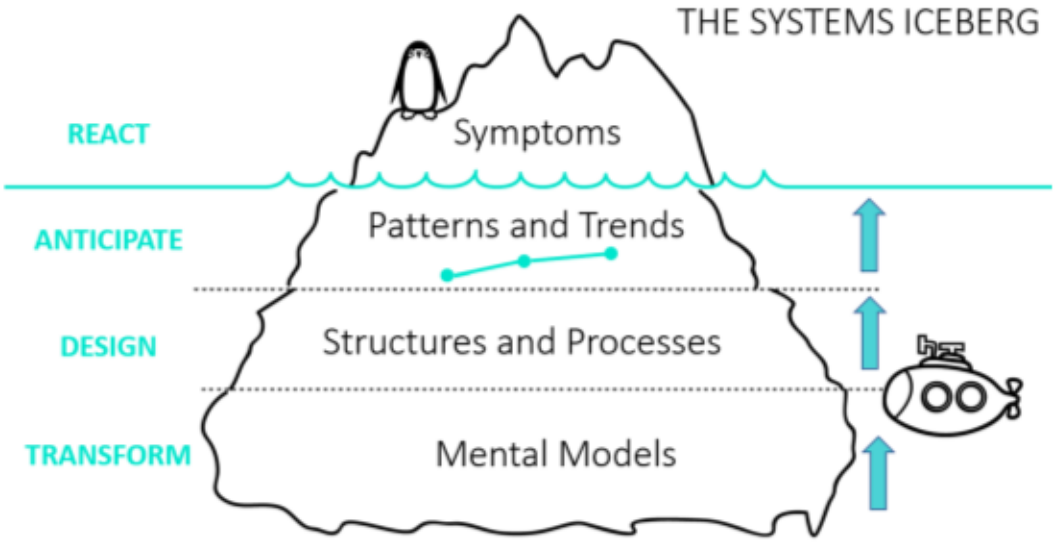
**When children are in a one-child staffed residential resource:** What has been informative to us is seeing that there is often a disconnect between what supports, practice and interventions are recommended in a plan for a child with significant needs and what the service provider is actually able to offer based on staff expertise and training, availability of complementary services and supports, etc. The child then doesn't do well in the resource because the plan isn't realistic, or being adhered to consistently or staff don't have access to the clinical expertise that could help them create a better plan. Staff struggle to provide care, the entry level staff that are often hired into the roles leave (as the economy is strong and it is relatively easy to get work elsewhere), the child loses connection and has more uncertainty in their lives, they express their distress in challenging ways and the cycle of harm continues. Sometimes this is due to contract limitations and inadequate staffing or clinical supervision budgets, sometimes it is because there is a lack of complementary services and supports to wrap around the child and resource so that they are successful, and sometimes it is a mismatch between organizational experience and expertise and the child (sometimes driven by lack of resources).

So there are both structural and practice actions. Structural considerations include: modifying contracting mechanisms, enhancing access to clinical supports and supervision, better training and supervision for staff who will be providing care (and yes adequate pay to attract and retain exceptional staff), etc. Practice considerations include: ensuring that the care we provide attends to the complexity and trauma that every child in this situation has experienced; being highly relational in practice and attuned to the moments when the child is doing well and what are the conditions that give rise to this – and doing more of that if safe; being child centred in planning (rather than staff-centric); working with and honouring the family's voice where possible to support their ongoing connection and belonging. We have story after story of a child being completely dysregulated in one resource and then moving to another resource with a different approach to practice and care and thriving.

**Before young children are placed in staffed care:** In some situations that we see, the family has asked for help for years before things really fall apart and the child comes into a staffed resource. Sometimes families are completely broken from trying and feeling unsupported and unheard. Because we are crisis and protection driven we are geared towards a more reactive response rather than proactive. Structurally, in what ways could it become more typical, rather than exceptional, to arrange very intensive supports to wrap around a child within their family so staffed care is not the default? From a practice perspective, how might we better support families (or foster families if a child must be in care) through the early years when concerns are first arising?

**Q. The patterns referenced by Jennifer have been present for decades and I understand they are exacerbated by the pandemic. I am unclear as to how we can make change if there is no political will /commitment. We advocate until we are blue in the face. How do we move forward against systemic barriers? (mtomioka)**

A. Yes – so true that this is familiar. And we keep saying the same things and some of the basic issues recur or get worse. This is one reason that we are trying to figure out what keeps us stuck, hence the systems iceberg model. What are the underlying patterns, mental models and structures that we might not even be consciously aware of that maintain the status quo?



**Q. Even something as simple as trying to hire folks with lived experience or folks who come from INCREDIBLE cultural knowledge/gifts is difficult because of colonial beliefs in the value of education and hiring qualification requirements that are written within our contracts and mandates. How can we build a sense of belonging within our programs and do the front line work effectively if we are so limited in how we hire our workforce? (Devon Murray, she/her)**

A. I agree with you Devon, this is indicative of the colonial mindset or mental model that privileges certain kinds of credentials over others. This is a structural and systemic issue. I think we can question this, try something different and assess impact and outcomes to demonstrate that it can be different. For example, in the RCY's postings a number of positions require graduate level education, so we have added the following to our job descriptions to reflect a more expansive understanding of graduate education:

"The successful candidate will ideally have education and knowledge at the level of a graduate or professional education. **There are many different ways in which this could be obtained** such as through:

- Formal post-secondary education at a Professional, Masters or PhD level in a relevant discipline (e.g., law, social work, child and youth care, psychology, sociology, public health, criminology, forensics, Indigenous studies, Indigenous governance, public administration, education, medicine, gender studies or anthropology).
- Structured, intentional teachings from Elders and Knowledge Keepers.
- Professional development educational and learning opportunities.
- Community, lived and work experience in which skills and knowledge are developed over time.
- First Nations or Métis political leadership or governance roles.
- A combination of formal and informal learning and education.

**Q. Could you speak to the impacts non-clinical supports (peer supports, mentors, youth workers) have on the children and youth you've worked with and how these compare to clinical supports? (Catherine Rana, FCSSBC)**

A. Interesting question. Service files, care plans, etc. are more likely to document the professional or clinical supports provided to a young person and not the informal or non-clinical supports that may be of importance or value to them, so we may not know about these supports. Even our advocates may not hear about these supports from other professionals. And if we go to a full investigation on a critical injury or death, it can be hard to gather some of this information as those involved in a young person's life may not think

about these other supports. Where we do learn more is when we are able to connect with the young person and hear their perspectives. If we come at this from a perspective of belonging, these informal or non-clinical relational supports are hugely important to complement the therapeutic care that a young person may need. Not an either-or but a both-and. I think we have a lot to learn about the ways to intentionally foster natural support networks (and can learn from the disability movement and initiatives like Planned Life Advocacy Network or PLAN)

## Comments

Well said Samantha. Trauma informed practice is about self-reflection, digging deeper, and understanding how our own issues further traumatize children and youth—the colonial system of diagnosis and band aid solutions instead of looking at families as holistic members of our village... That we are responsible to those that came before us and to those that come after us, we need to change our value system before we can change the system. (Kendra Gage, Hulitan, she/her, on Lek'wenen traditional territory)

We need to privilege youth and families voices and move away from paternalism. (Alexi Frigon, He/Him)

[On whether to move CYMH into the health care system] Moving MH into a systems that is non collaborative, expert and diagnosis driven  to address trauma would be going backwards.

## Offerings: Trauma aware resources

From Amanda: Complex Trauma Resource Site

From RCY: Vikki Reynolds Website

## Offerings: RCY reports:

Part 1: COVID and Anticipated Mental Health Impacts

Skye's Legacy – A Focus on Belonging