

A New Funding Formula

Child and youth mental health services are funded primarily through the Ministry of Children and Youth Services through an annual allocation of approximately \$500 million (2007-8) for “Child and Family Intervention”. Of this amount, \$434 million (86%) is provided to approximately 440 transfer payment recipients, of which approximately 370 receive an ongoing funding allocation. (The amount of expenditure for child and youth mental health services by the Ministries of Education and Health and Long-Term Care is unknown.) In 2008, the Auditor-General reported that about one-third of the increase in transfer payments between 2003 and 2008 was due to base funding increases that applied equally to all agencies, while the balance was due to new program initiatives or the transfer of activities into the program. In its June 2010 interim report, the Select Committee on Mental Health and Addictions stated that “agencies are struggling to maintain core services because funding is tied to historical needs and population”. The Auditor-General also noted in 2008 that (1) “children’s mental health services can be provided only up to the system’s existing capacity, which is determined largely by the amount and allocation of ministry funding rather than need” and (2) “nor were they based on data showing which services should be provided in which communities for which disorders”.

The **mandate** for this sub-committee is to propose an approach to funding CYMH services that will be based on the current and evolving needs of children, youth and families rather than being tied to historical allocations. The sub-committee will **recommend** principles to guide funding decisions, factors to be considered in determining need, and an approach to managing the transition from existing funding arrangements to new ones. The sub-committee will **consider** how ‘communities’ will be defined for the purposes of funding allocations; whether regionally-based mechanisms or processes should be established to make funding decisions; whether some funding should be allocated to facilitate and incent system change, such as greater service integration, collaboration among agencies, or navigation support for clients; and other relevant matters.

Equity for Under-Served Populations

Although chronic under-funding of child and youth mental health programs has led to unmet needs and long wait times for young people and families throughout Ontario, several population groups face an extraordinary gap between their mental health needs and available services. The current system is particularly deficient for aboriginal children, children of immigrant families, those in the child welfare and youth justice systems, those who are approaching or just past the age of 18, children with developmental disabilities, and many children living in rural and remote communities, among others. Resources and services for francophone children and families are also too often unavailable. As the recent Ontario Select Committee on Mental Health and Addictions reported: "Youth are caught in the gap between programs for children and adults ... First Nations people struggle with above-average rates of mental illness, addictions, and youth suicide ... Francophones are misdiagnosed because they are not treated in their first language. Linguistic and cultural barriers may also affect newcomers and refugees. ... Similarly, individuals with autism, eating disorders, Fetal Alcohol Spectrum Disorder, or a dual diagnosis are orphaned by a system that seemingly has no place for them."

The **mandate** for this sub-committee is to propose an approach to closing extraordinary population-based gaps between needs and services, in order to achieve greater equity. The sub-committee will **recommend** criteria and a methodology to identify population groups that are most seriously under-served by the current child and youth mental health system, and a strategy for developing services and programs that will meet their unique needs. The sub-committee will **consider** the extent to which targeted and/or specialized programs and services should be developed; the potential for community-based and population-based approaches; cultural and geographic factors; human resource and professional development implications; an approach to prioritizing access to scarce resources; and other relevant matters.

Establishing Service Standards

The Auditor-General's 2008 report noted that "partly because of the lack of a legislated mandate, children's mental health services were, historically, not developed in an orderly and uniform fashion across the province". One of the priorities for action in "A Shared Responsibility", the Ontario government's 2006 policy framework for child and youth mental health, is to "identify and develop service standards". The June 2010 interim report of the Select Committee on Mental Health and Addictions stated that "children with the same mental health condition have different wait times and treatment depending on where they live". The Auditor-General's 2008 report also stated: "The vast majority of services provided by agencies is delivered in a non-residential setting, and the only legislated or Ministry-mandated case management requirement for their services is to complete a CAFAS evaluation upon the individual's entry to and exit from service. However, three of the four agencies we visited had developed their own case management policies and procedures for many of their non-residential programs, as is required by CMHO's accreditation process." Of the 370 transfer payment agencies funded on an on-going basis by the Ministry of Children and Youth Services, only approximately 85 are accredited and some may be using Child and Family Intervention (CFI) funding to deliver programs unrelated to child and youth mental health treatment. MCYS mapping data from 2008 revealed that 18% of the children being served through programs funded as part of CFI were neither experiencing nor at risk of mental health problems.

The **mandate** for this sub-committee is to propose an approach to developing, implementing and monitoring consistent service standards for non-residential and residential Ministry-funded programs. The sub-committee will **recommend** the domains in which standards should be established, principles that should guide the standard-setting and enforcement processes and, where feasible and appropriate, the content of specific standards. The sub-committee will **consider** the appropriate roles for accreditation, regulation and other approaches; whether standards should define the scope of practice eligible for Child and Family Intervention funding; whether wait time standards should be established; how cost-of-service considerations should be addressed; whether differential standards are required for agencies of different sizes or expertise; whether caseload standards would be desirable and practical; and other relevant matters.

Integration/Coordination of Services

Children, youth and families with mental health needs often access diverse services from a variety of sectors and may even receive mental health services from several providers as their age and needs change. Goal #1 of “A Shared Responsibility” is “a child and youth mental health sector that is coordinated, collaborative and integrated at all community and government levels”. The priorities for action to achieve this goal are: enhanced integration within and across ministries and sectors; effective transitions across developmental stages, education transition points, adolescent to adult services and hospital-based to community services; and easier navigation among mental health services by children, youth and their families. The Auditor-General’s 2008 report states that “children and youth who exhibit symptoms of mental health disorders are most often referred to services through one of four gateways – schools, the child welfare system, families and physicians”. The report also notes that “it is often at school that signs of mental health disorders in a child can first be detected ... However, unless the educators are well trained in mental health issues, principals and teachers may be unaware of what signs to look for and uncertain what their role should be or who they should be contacting”. The June 2010 interim report of the Select Committee on Mental Health and Addictions also noted that post-secondary students “have a high risk for mental illness” and that “sector is considered an ideal setting for promotion and early intervention strategies but ... partnerships are needed”. About one-third of permanent wards in Ontario have mental health disorders (Burge, 2003; quoted in MCYS Mapping Results, p. 8). Over 60% of youth in the justice system have diagnosable mental health and substance abuse problems (Howlett, 2008; quoted in MCYS Mapping Results, p.8).

The **mandate** for this sub-committee is to propose approaches to guide more integration and coordination of child and youth mental health services within communities and across sectors. The sub-committee will **recommend** principles that will guide the organization and delivery of child and youth mental health services across multiple sectors, strategies and actions for improving access to and integration of mental health services for children and youth in specific priority sectors (e.g. education, child welfare, youth justice), and measures to improve transitions between child and youth mental health agencies and other service providers (e.g., adult mental health, physicians, hospitals). The sub-committee will **consider** the recommendation of the Select Committee on Mental Health and Addictions that all mental health programs be coordinated through a new body that reports to the Ministry of Health and Long-Term Care; the extent to which mental health service capacity

should be developed separately within each sector; the extent to which services should be contracted from and/or referred to child and youth mental health agencies; the role for common measures, tools and terminology; the potential for shared programs (e.g. professional development) and staffing; and other relevant matters.

Reducing Teen Suicide

Suicide is the leading cause of non-accidental death among 10-24 year olds in Canada, and in 2006 accounted for 18 percent of all deaths in this age group. On average, nine young lives are recorded as lost through suicide every week across the country, including 3 per week in Ontario – and it's widely believed that these numbers are under-reported. The Organization for Economic Cooperation and Development (OECD) recently reported that Canada's suicide rate among 15-19 year olds is the 4th highest among its 29 member countries. Although significantly more girls attempt suicide, boys are more successful because they tend to choose more violent means. Psychiatric disorders are the most significant risk factor for youth suicide: up to 90 percent of people who have completed suicide were dealing with depression, problem substance use, and/or another diagnosable disorder. Unlike many other jurisdictions, neither Canada nor Ontario has a suicide prevention strategy.

The **mandate** for this sub-committee is to propose an approach that will reduce the incidence of youth suicide and suicidal behaviour in Ontario, and reduce the effects of youth suicide on families, friends and communities. The sub-committee will **recommend** the core elements of a provincial youth suicide reduction strategy, including initiatives related to public awareness, early identification and intervention, community-based approaches to reduce the risk of suicide within at-risk population groups, and support services for Ontarians affected by youth suicide. The sub-committee will **consider** the development process and the content of suicide reduction strategies in other jurisdictions; which stakeholders should be engaged in developing and delivering a youth suicide reduction strategy for Ontario; the role of stigma and media reports in reducing suicidal behaviour; the evidence of programs that have been effective in Canada or elsewhere; and other relevant matters.