# "Stay the Course…
# and Together We Can Secure the Foundation
# that Has Been Built"

## *Supplementary Report: Children and Youth*

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Submitted to:

The Department of Health and Social Services
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# Child and Youth

This supplementary report on Child and Youth is part of the larger report titled: **"Stay the Course… and Together We Can Secure the Foundation that Has Been Built ",** an Interim Report on the Mental Health and Addictions Services in the NWT, December 9, 2005.

The main purpose of these supplementary reports is to provide background information, linkages to the mental health and addictions research in the field, and greater explanation of the recommendations. The format of these supplementary reports is such that, they can be read on their own. As well, there is overlap of the findings/recommendations with the Interim Report.

However, this supplementary report and others do not provide a complete review of the relevant research on this topic, as time and resources did not permit this review during the six weeks allotted to this work in 2005. Nevertheless, the reader can be assured that these supplementary reports provide a good overview of the relevant issues for the ongoing work in the mental health and addictions core service in the NWT.

## 1. Background Information

### What do children and youth need?

There is no easy answer to this question. Every child is different. They have strengths and weaknesses, talents and limitations. They begin life in different circumstances, and experience life through different circumstances, cultures, languages, environments and so on.

But there are certain things children generally need in order to develop. These developmental needs are the things a community and family will want to provide for its children. Each is a kind of doorway that children need to step through on their way to becoming adults. A door can be an opportunity that opens easily, or a door can be heavy, a barrier and challenge to open. For some children, the door is stuck shut.

Children need food, clothing, shelter, love, enrichment, stimulation, opportunities, safety, love, nurturing, encouragement, discipline, boundaries- and the list goes on. Researchers refer to these determinants of healthy development, which can be generally grouped into four key areas: protection, relationships, opportunity and hope and community (Canadian Institute of Child Health, 1997).

- Protection: children need to firstly be protected from harm and neglect, racism, discrimination and poverty.

- Relationships: humans from all cultures need others to thrive physically and emotionally. Relationships change over the course of a child's life from a healthy bond with mother/caregiver, to play friends, to school peers and lastly to social peers.

- Opportunities: children need exploration, learning, sharing, taking and giving, testing their abilities; this is mainly done through exploration, play, education and negotiating one's environment.

- Community: children grow up in a family and a community, which has support networks all around them. Communities need a strong sense of connection and social cohesion to foster the conditions that make for optimal child development.

"It takes a community to raise a child."

It is clear from the above overview of healthy child development that children and youth need to be free of mental health problems, and live in environments without addiction, family violence and trauma.

## 2. Abbreviated Literature Review

A full review of the mental health and services for child and youth is beyond the scope of this Supplementary Report. What is relevant is to give information from a broad perspective.

**What does the research tell us about preventing mental health, addiction and family violence problems from developing in the first place?**

Research has identified many key factors with respect to mental health, addictions and family violence and healthy child development:

**1) Early intervention**

Good things that happen early, particularly during sensitive periods of brain development in the first three years of life.

**2) Children are resilient**

It is important to not write off children who get off to a bad start developmentally. Research shows that children who begin life in difficult circumstances, can bounce back later if they get what they missed early in life - it is just more difficult and potentially more expensive.

**3) Children can use multiple pathways, resources to become healthy**

Determinants of healthy development seem to work best, if they are reinforced over time, and in a number of environments.

**4) Belonging, connectedness, family and community**

Combinations of positive factors within a caring community, can mitigate against other negatives. For example, a dynamic school that involves parents, together with a safe and caring community that supports recreation, youth activities and youth as future leaders, provides a combination of positive forces that reinforce each other.

**5) Programs tailored to the developmental phase of the child**

Approaches to healthy development are outlined by three age groups:

| Age Group | Focus of Prevention |
|---|---|
| 0 to 6 years (early childhood) | Prenatal/Postnatal programs<br>Home visitation,<br>Childcare initiatives, preschool<br>Aboriginal Head Start/culture based<br>Healthy Parenting<br>Traditional Parenting<br>Healthy Families-preventing abuse<br>Play groups |
| 6 to 12 years (school age) | Social Skills Programs<br>Recreation, youth clubs,<br>School recreation/sports<br>On-the-land/culture based programs<br>School life-skills programs<br>Crime Prevention Programs<br>Parenting support programs<br>Educational support programs |

| | |
|---|---|
| 12 to 18 years (Youth) | Educational support programs<br>Youth counselling/peer counselling<br>Community recreation programs<br>Promote healthy behaviours-anti-smoking, drinking<br>Healthy relationships focus<br>Youth employment/career support |

**What are evidence-based practices, best practices once children/youth have developed problems?**

Below is a broad list of evidence-based practices for children and youth with mental health and/or addictions taken from a number of sources (Health Canada, 2001; Bloomquist & Snell, 2002).

1) Individualized and tailored counselling to the child's development, culture, social background and interests (for example children who like to draw can benefit from art therapy strategies).

2) Address overarching housing, food and safety issues prior to doing counselling.

3) Provide services within the context of family, community and culture.

4) Show respect and trust, regardless of age of child; follow applicable procedures for confidentiality, informed consent for jurisdiction. This may preclude disclosing information to parents and guardians.

5) Maintain safe counselling practices, and acknowledge duty to warn and protect, in addition to other ethical guidelines.

6) Provide counselling services within one's scope of experience and training.

7) Integrate counselling with educational or social settings, where possible.

8) Consider use of art, play and narrative focus with children and youth; would require applicable training and experience.

9) Work within a strength based approach that emphasizes positives.

**10)** Build positive rapport with youth; become a support for them.

"Children are not little adults, but someday they will become an adult."

**What is happening elsewhere with mental health and addiction services for children and youth?**

In many jurisdictions across Canada, there is a decentralizing of children's and youth services to community-based agencies that specialize in services for children or conduct research with children and youth.

In a broad review of 20 child and youth specific services across rural Alberta and British Columbia (done for this review), 19 of the 20 child and youth services were integrated with family or adult services. In urban settings, or large cities the effect was the opposite, in that child and/or youth services were distinctive from adult services. Therefore it would appear that rural areas provide integrated services for adults, children and youth. It could be hypothesized that resources, expertise and "economies of scale" do not justify specialized youth and children's services in rural areas.

Another interesting pattern noted in reviewing different provincial governments across Canada is the separation or integration of child and youth mental health and addictions services with other child-focused areas. A few comparisons are listed here of how different provincial governments address the structural placement of child and youth services:

British Columbia: Has a Ministry of Children and Family Development, which is inclusive of child protection services, child care, early childhood development, and services for adults with developmental disabilities.

Alberta: Has Alberta's Children's Services, which is inclusive of child protection and intervention services, family and community support services, FASD, Family Violence services, early childhood services and child care services and accreditation.

AADAC, or Alberta Alcohol and Drug Abuse Commission, provides addiction services for youth. There have been recent expansions of youth treatment beds that are specific for Crystal Meth and Street Youth.

Saskatchewan: Saskatchewan Health provides mental health services separately for children/youth and adults. Addiction services are provided throughout the province for both youth and adults in each Authority. A separate department, Saskatchewan Community Resources and Employment, provides child protection services, and early childhood programs. Saskatchewan has a government children's advocate office to speak for children.

| | |
|---|---|
| Manitoba: | Mental health and addictions are integrated within Manitoba Health. Services for children and youth are provided through health authorities. Child protection services are provided under a separate department, Manitoba Family Services and Housing. |
| Ontario: | The Ministry of Children and Youth Services provides mental health, addictions, child protection and youth justice services. |
| Nova Scotia: | The Ministry of Children, Youth and Families provides child protection services, early childhood services, prevention and family violence, and assistance for persons with disabilities. |
| Newfoundland & Labrador: | The Department of Health and Community Services provides child, youth and family services, child protection, and health services. There is also a child and youth advocate within the Department of Health and Community Services. |

## 3. Findings from the NWT: Child and Youth

In 2001, child and youth services, or the lack thereof, were raised occasionally in the "State of Emergency Review…" (2002).

In 2005, many interviewees in all regions spoke of the importance and urgent nature in developing systems for children and youth.

In fact, concern about services for children and youth was the most common issue raised throughout the review done for this interim report, with residential treatment being the second most common concern raised by interviewees across the NWT.

### Areas of Success/Strength

- History of Services in the NWT

  Addiction services have been provided in various forms in the NWT since the 1980's and likely before this as well. Although child and youth specific services are not as visible, there have been efforts and approaches used to address the mental health and addiction needs of NWT youth.

Currently, several community counselling programs are engaging in expanded services for children and youth. Also, a child psychiatrist has been providing services to predominantly Yellowknife children for many years. Also, when funding was available, a number of pilot projects were introduced in the form of child support programs, play therapy programs and others (through Healthy Children's Initiative).

There are also many prevention-focused programs addressing the broad health needs of children/youth, throughout the NWT; these programs are largely funded through community-based funding schemes such as Brighter Futures, Crime Prevention, Healthy Children's Initiative and others. Also, suicide intervention programming has targeted young people in some communities across the NWT. These are strengths to build from in the NWT with respect to child and youth services.

§ Community Counselling Program

Historically, community addictions workers, mental health specialists (1990's), and others have assisted at the community level to form informal supportive systems for dealing with crisis situations involving youth.

**Areas for Further Strengthening and Development**

- Crisis Focus with Youth and Residential Treatment

It is recognized that often youth present in crisis for mental health or addiction services. It is often easier to refer them to a residential treatment program out-of-the-territory for "safety reasons" and to protect the youth from further self-harm. It is uncertain if a brief crisis, which could be stabilized locally, merits a full residential treatment program.

The nature of many youth specific mental health issues is crisis oriented. This needs to be managed and stabilized prior to residential treatment planning. There may be a "behavioural reward" pattern learned by youth in crisis to seek treatment.

Residential treatment for youth and adults is also best received when withdrawal management, issues of a crisis nature and family turmoil are stabilized.

- Expertise requires team approach

  Child and Youth policy, planning and collaboration work requires a selective expertise in child and youth programming, but also an overlap with adult/family mental health and addiction services. The unique expertise in working with children and youth is likely best achieved through a group of people who have worked in various aspects of child and youth mental health and addiction services and policy development.

## 4. Discussion & Recommendations

It needs to be recognized that this final section on child and youth services is based on the evaluation team's review of the current context of mental health and addictions services in the NWT. It is by no means exhaustive, and much more could have been added with greater consultation, and report development time.

However, it does provide a snapshot of the evaluation team's impressions, which may be useful for future planning, design and implementation of child and youth services. This is likely the most challenging area of the new core service, that is, addressing the needs of children and youth.

## *We encourage:*

**1) Collaborative practice, and taking time** to study the relevant issues with a broad group of stakeholders: community personnel, leaders, agencies, professionals (child psychologists, psychiatrists, pediatricians, neuropsychologists, speech-language therapists, public health nurses, educators, early childhood workers, childcare workers, corrections/community), parents, elders, …

For example, The NWT Sexually Transmitted Infections (STI) Strategic Directions Document highlights the need to strengthen school-based sex education and health programming. Collaborating with these prevention efforts would be beneficial for youth, as alcohol and drug use patterns are often associated with STI (GNWT, 2005).

**2) Making use of clinical personnel in the NWT** who possess child and youth expertise, such as in Beaufort-Delta and Deh Cho, and other areas.

**3) Continuing efforts within the DHSS** to establish a core working group and to understand where gaps and challenges exist across the NWT.

**4) Seeking additional expertise in child and youth** approaches to work with DHSS stakeholders and others. There is no one person who has all the relevant expertise in child and youth.

**5) Prioritizing child and youth services** within the core service of mental health and addictions.

**6) Building on strengths** from existing community counselling programs, and PCCT, in addition to other community partners that have a relevant part to play with children and youth (recreation, school, early childhood).

**7) Maintaining and further enhancing funding** resources for the Community Counselling Programs that which could form the stability of child and youth services across the NWT in mental health and addictions.

**8) Children/youth need to be within the context of family/community.** Children and youth with mental health, addictions or other developmental challenges are rarely separated from issues in the family and community.

**9) Community Mental Health Counsellors, Wellness Workers and Clinical Supervisors to refer children and youth to experienced personnel**, should they feel ill-equipped to address child and youth issues. Although it is desirable to have all community-based counselling staff be proficient in working with children and youth, it is not possible, nor ethical, to work with cases for which one has no training.

Most often, child and youth mental health clinicians are trained at the Master's and Doctoral level of Psychology or Social Work, and have many years of experience under expert supervision. Also, there are different skill sets needed to work with children and different ones to work with youth in a therapeutic setting (Geldard & Geldard, 2005).

It is possible for most NWT community-based workers to develop screening, crisis skills and brief approaches to work with children and youth; these are important skills needed for NWT personnel who work in isolated areas.

**10) Ongoing work to help NWT children and youth.** There remains far too much addiction, family violence, depression, suicidal ideation, exposure to trauma and developmental problems such as FASD, ODD, ADHD and others in youth and children across the NWT. Despite population stabilization in recent years, children and youth in the NWT still make up a sizeable part of the population and are in need.

## *We suggest be careful:*

**1) Implementing the "miracle" program** or service across the NWT that will save all the children and youth. There are thousands of effective, pre-packaged child/youth intervention approaches across North America that have an evidence-base rate of effectiveness.

There is no one solution or program that can effectively address mental health and addiction issues. It is a combination of promotion, prevention, early intervention, family/community initiatives, socio-economics and many other factors that collectively determine health of children and youth.

**2) Allocating resources/management systems to child/youth only.** This is inconsistent with holistic and community-based counselling programs that were designed to meet the needs of all residents of the community. It may be practice in other Canadian jurisdictions to have distinctive child and youth services, but these areas service larger populations, and have greater breadth of human resources and expertise.

There may be a need to increase expertise at the community level, and incorporate regional child/youth specialties for crisis youth, trauma and more complicated cases.

**3) Breaking off child/youth from the core service** of mental health and addictions and placing this focus with child protection. This is a DHSS-specific caution, in that the current structure and expertise within the child and family services unit is specific to social work, child protection and residential group home management expertise in a southern location.

This review team did not view the current mix of personnel, including management, within the child and family services unit, as possessing the required skills, expertise, and clinical experience to oversee and develop child and youth prevention, mental health and addiction services.

> "A geographical cure is rarely the answer…"

## *We suggest avoiding:*

**1) Residential treatment programs as the answer** to child and youth problems in the NWT. Although "bricks and mortar" was discussed during the interviews for this review, it is suggested that building or developing a child and youth treatment centre is premature, at this time, in the NWT.

Problems in hiring skilled staff, maintaining sufficient numbers of children/youth at the same time, and disconnection from community and family are three main reasons for this recommendation.

The population and numbers of children/youth requiring specialized, residential treatment do not justify NWT residential treatment at this time. Calgary and Saskatoon, have only just recently increased their numbers of residential spaces for street youth to just under 20 beds, and their service areas are far larger than the NWT.

Further development of regional assessment services for youth (standardized, evidence-based and with skilled workers) will provide the best use of financial resources for the NWT as a whole.

**2) Housing children and youth in residential type programs,** as this repeats the history of residential schools.

Most evidence-based child and youth services are community-based, outpatient focus, and are linked with family and/or school systems. Residential type services are, by practice, a last resort for children.

**3) Becoming "program junkies"** with child and youth. This refers to developing many different programs and services. Holistic, community-based and integrated service is what is needed, and not a separate design, delivery and implementation for child and youth. There can be a child and youth strategy, but we recommend an integrated one with community and family.

4) **Duplication** of prevention efforts that are widespread throughout the NWT in various forms and funding arrangements with Federal and Aboriginal organizations. There are many mental health focused programs that are delivered in community schools, through renewable resource programs, crime prevention through social development initiatives that are largely community-based.

**5) Areas already being addressed at the community level, and through other GNWT departments.**

For example, early childhood programming, and the expanded focus from the Federal Government through ELCC or single window. This approach is about to influence how all early childhood services are delivered across the NWT by a change in funding patterns for many federally funded and GNWT funded programs. This complicates any directions the DHSS may take in addressing mental health and social-emotional needs of children across the NWT in the immediate future.

It is important to be abreast of all areas of program, management and funding that could influence child and youth services, as they are represented in several federal and territorial departments.

**What do the people say?**

"We need more services for children and youth, they are our future."

"I like to work with children, but my workload dictates otherwise."

"I am not always comfortable sending our kids out of the territory for treatment, it just reminds me too much of residential schools, and I wonder if we doing more harm than good."

**Next Steps/Further Recommendations:**

Planning, study and much consultation are required to proceed with specialty services for children and youth. It is recommended that children/youth services be enhanced within the context of families and communities in the NWT, and therefore integrated with core mental health and addiction services in the immediate future and over the next three to five years.

Consider the development of a mobile assessment service that could serve small and isolated areas, either through tele-health, regional locations or through a mobile structure. This may be a service targeting children, youth and families.

Develop multi-disciplinary assessment processes that are inclusive of child and youth priorities, and within a family and community context.

**Specific Recommendations for Drugs**

1. Strategic approach to address the changing patterns of illegal drugs in the NWT:

    a) early intervention – building healthy families. (Ongoing)

    b) healthy children, social skills, healthy relationships and bodies, stay in school focus. (Ongoing)

    c) educate, educate, educate of dangers/problems and get help early on. (Ongoing)

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