



DESPERATELY WAITING

..... MARCH 2022



SASKATCHEWAN
advocate
FOR CHILDREN & YOUTH



Letter of Transmittal

March 29, 2022

The Honourable Randy Weekes
Speaker of the Legislative Assembly
Legislative Building
2405 Legislative Drive
Regina, SK S4S 0B3

Dear Mr. Speaker:

Pursuant to section 14(3) and in accordance with section 28 of *The Advocate for Children and Youth Act*, it is my duty and privilege to submit to you and members of the Legislative Assembly of Saskatchewan this special report, entitled *Desperately Waiting*.

Respectfully,

A blue ink signature of Lisa Broda.

Lisa Broda, PhD
Advocate for Children and Youth

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Advocate's Executive Summary

The Saskatchewan Advocate for Children and Youth is an independent officer of the Legislative Assembly of Saskatchewan. As a voice for young people, the Advocate's mandate is defined in accordance with *The Advocate for Children and Youth Act*, which sets out the legislative authority and responsibility foundational to the position and work of the office. Our work—and this project—is grounded in the United Nations Convention on the Rights of the Child (UNCRC) and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), both of which are foundational to the Advocate's strategic priorities that ensure the voice of children and youth is represented in the work of our office.

This report, entitled *Desperately Waiting*, is reflective of our mandate to conduct research with the overarching goal of elevating the rights, interests and well-being of Saskatchewan children and youth through the direct experiences and perspectives individuals have shared regarding youth mental health and addictions services.

The scope of this work is a representation of a myriad of concerns that our office received over past decades through our advocacy, investigations, research and system work regarding the challenges children, youth, parents/caregivers and staff working within child-serving systems have faced in accessing mental health and addictions services and supports for children, youth, and families. Concerns regarding self-harm, suicidal ideation, suicide attempts and completed suicides, particularly in our investigations of children deaths and injuries we see year over year. The profound impact of poor mental health and poor well-being of children and youth in Saskatchewan can sadly lead to the gravest of outcomes.

This work involved travelling corner to corner across the province to speak to stakeholders about their experiences related to services within the mental health and addictions system. We met with 491 individuals and groups that included children, families, professionals in the health system and other child-serving systems who shared their experiences. Our purpose was to seek information about what works within the mental health and addictions system for children and youth, to identify any barriers and challenges in accessing the system and what solutions could be implemented to improve the system. Several thematic findings that emerged from a significant data set are presented in this report:

- A Reactive vs. A Proactive System
- Navigating Mental Health Services
- Access to Culturally Appropriate Services
- Hospital and Acute-Care Services
- Lack of Integrated Services
- Need for Increased Knowledge, Tools, and Capacity
- Supporting Youth Transitioning to Adult Mental Health and Addictions Services

Participants described a system that is predominantly reactive without sufficient processes established to intervene early when mental health problems in children are identified. The social determinants of health – poverty, lack of housing and educational achievements – and adverse childhood experiences – all forms of abuse and neglect, parental separation, and parental mental illness – were identified by young people and adults alike as being the social

drivers undermining the mental health of our children and youth. When children and youth struggle or find themselves in a mental health crisis, the theme on navigating mental health services describes some of the challenges experienced with the availability of mental health providers, and lack of accessibility due to factors such as intake processes or transportation.

There is a need for more Indigenous mental health counsellors and to leverage Indigenous worldviews, culture and traditions when working predominantly with the Indigenous children and youth population. Hospital and acute-care services and addictions (detox and inpatient treatment) are both themes where participants identified barriers as well as improvement solutions. Lack of integrated services reflected by limited information sharing and collaboration among all child-serving systems was an important theme for consideration of the serious consequences that can occur in these circumstances.

Almost every participant group discussed the need for knowledge and skill-building to enhance confidence in providing services and supporting young people. A theme on the transition to the adult system when young people turn 18 years old can result in barriers related to waitlists and lack of mental health support on a continuum of care basis. In addition, participants raised attention to other child-serving systems and their impact on the mental health of children and youth, including education, child welfare, and justice. Several recommendations emerged from these findings and are represented below:

RECOMMENDATION #1

The Ministry of Health and the Health Authorities develop and implement Youth Advisory Councils to incorporate youth perspective in the design of services, programming models and evaluations, and to inform leadership about the needs of young people who obtain these services.

RECOMMENDATION #2

The Ministry of Health and the Saskatchewan Health Authority satisfy, without further delay, the Mental Health and Addictions Action Plan "Recommendation #2" which states:

"Decrease wait times for mental health and addictions treatments, services and supports to meet or exceed public expectations, with early focus on counselling and psychiatry supports for children and youth."

RECOMMENDATION #3

The Ministry of Health, Ministry of Education and the Saskatchewan Health Authority expand the Mental Health Capacity Building initiative across the province.

RECOMMENDATION #4

The Ministry of Health, Ministry of Education, the Health Authorities and school divisions work jointly to fund and implement a greater presence of mental health counsellors and Indigenous Elders/Knowledge Keepers in schools.

RECOMMENDATION #5

The Ministry of Health and the Saskatchewan Health Authority expand outreach-based mental health and addictions services by:

- the provision of service through a variety of modalities;
- hours of operation based on the needs of child and youth clients; and,
- inclusion of children and youth in the design of their individual service delivery.

RECOMMENDATION #6

The Ministry of Health, Ministry of Education, the Health Authorities and all school divisions adopt a consistent approach to “consent” for children and youth to receive mental health and addictions counselling based on the evolving capacities of the child rather than age.

RECOMMENDATION #7

The Ministry of Health and the Health Authorities provide in-home support services to families who require this service to maintain care for children with mental health and/or addictions related needs at home.

RECOMMENDATION #8

The Ministry of Health and the Health Authorities develop and lead a “middle-tier” care option to provide therapeutic residential placements for youth with mental health needs that are greater than can be managed in their home and/or with outpatient services, but who do not meet the criteria for acute psychiatric inpatient treatment.

RECOMMENDATION #9

The Ministry of Health and the Health Authorities formally evaluate the current detox and addictions treatment model to determine whether it is appropriate for meeting the current needs of youth in relation to the:

- evolving type and severity of problematic substance use;
- availability and accessibility of inpatient treatment;
- transitions between detox and inpatient treatment; and,
- transitions from inpatient treatment to the community.

RECOMMENDATION #10

The Ministry of Health and the Health Authorities enhance and expand culturally appropriate services that are integrated within the continuum of mental health and addictions services, including:

- broader representation of Indigenous service providers in Western-based models of treatment; and,
- greater availability of wellness and healing approaches grounded in Indigenous ways of knowing across urban, rural, and remote communities.

RECOMMENDATION #11

The Ministry of Health and the Health Authorities improve transitions from child and youth to adult mental health and addictions services by:

- increasing the age of transition to 25; and,
- allowing young adults to maintain treatment by their child/youth service providers until they are connected to a parallel adult service.

RECOMMENDATION #12

The Ministry of Health and the Health Authorities complete provincial implementation of the electronic Mental Health and Addictions Information System (MHAIS) to guarantee all those involved with youth mental health and addictions services across community, emergency, and inpatient services have access to the information required to provide seamless, effective service in the best interests of children and youth.

RECOMMENDATION #13

That all child-serving Ministries – including Health, Education, Social Services, Justice and Corrections – and the Health Authorities develop and implement an integrated service delivery model to enhance communication and coordination to support better outcomes within the mental health and addictions continuum of care services provided to children and youth.

RECOMMENDATION #14

The Government of Saskatchewan develop a 'Children's Strategy' to address and improve prevention related to the social and environmental factors that negatively impact the well-being of children and youth. This strategy must include the participation of all child-serving ministries and a designated official to lead the process.

The details regarding the rationale for these recommendations can be found in the body of the report. Much of what we heard during our review is not new, and the experiences laid out in the stories of Waylon and Jess certainly illustrate the challenges and gaps in service provision. The Ministry of Health and Saskatchewan Health Authority will be familiar with some of these recommendations, as similar ones were made in the Mental Health and Addictions Action Plan released in 2014, and these connections are referenced throughout the report. However, until children can fully access their rights to the full scope of mental health and addictions services, their well-being will continue to suffer. The consequences of the pandemic have only exacerbated the mental health problems for young people and the best possible outcomes for children will be out of reach if the system does not work faster to address the issues.

There is no question – we cannot continue to accept the current state of service provision as it is. Our report clearly shows that these issues have persisted for at least over two decades. We cannot expect outcomes to change without significant investments and for the system to immediately prioritize the implementation of the recommendations for these changes. Saskatchewan children are 'Desperately Waiting'. It's time to act.

We graciously thank the children and youth who spoke to us about their experiences, as it is my duty under the authority of our Act to put their voice at the fore on matters that impact their well-being. We also thank all of those across the province and in all child-serving sectors who took the time to talk to our office, to share their experiences and perspectives of a system that is sorely needing significant change for better outcomes for Saskatchewan children. I would also like to express my deepest gratitude for the staff who led the groundwork, data analysis, and writing of this report, and all staff involved who worked tirelessly to bring this report to fruition. It is our privilege to present this report and to honour the voices of children, families, stakeholders, and those who work in all systems that serve children.

Lisa Broda, PhD
Saskatchewan Advocate for Children and Youth

“It’s kind of the same problems that have been around for a while.”

- Youth Advisory Council

1.0

Introduction

1.1 Advocate's Mandate and Foundation of Rights

The Saskatchewan Advocate for Children and Youth works to advance the rights, interests and well-being of young people across the province who receive services from a provincial government ministry, agency or publicly-funded health entity. As an independent voice for young people, our mandate is defined in accordance with *The Advocate for Children and Youth Act*, which sets out the legislative authority and responsibility that is foundational to the position and work of the office.

Our Act guides the Advocate in addressing issues and gaps in services that affect children and seeks to find resolution in a fair, impartial, transparent and non-adversarial manner wherever possible. We do this through the core functions of the Advocate's mandate, which include advocacy, investigations, public education and research.

Our work is grounded in the [United Nations Convention on the Rights of the Child \(UNCRC\)](#)¹. The UNCRC is the most widely ratified international human rights treaty in history. In general, human rights are the globally recognized foundational elements necessary for equality, respect and dignity. The UNCRC confirms that children and youth are entitled to the broad range of human rights inherent to every person and recognizes special protections for children due to their age, their limited ability to participate in political processes and their dependence on adults to make decisions for and about them. Canada ratified the UNCRC in 1991, thereby becoming legally obligated to respect the rights of children codified within. Provincially, the Government of Saskatchewan affirmed its commitment to uphold the UNCRC when it adopted the [Advocate's Children and Youth First Principles](#)² in 2009.

The priorities of the Advocate also include the principles of reconciliation aimed at building awareness of the long-term consequences and harms caused to Indigenous peoples, respecting Indigenous beliefs, cultures, traditions, and worldviews, and taking action to ensure respect for and protection of the rights of Indigenous children, youth, and families. Our work aligns with the [United Nations Declaration on the Rights of Indigenous Peoples](#)³ which, in part, calls on governments to ensure Indigenous children are afforded special protections, and the [Touchstones of Hope for Indigenous Children, Youth and Families](#)⁴, which promotes reconciliation in child-serving systems through recognition of self-determination, respect for culture and language, non-discrimination, redress of structural inequalities and the need for a holistic approach to repairing the harms of the past.

Pursuant to Section 14 of *The Advocate for Children and Youth Act*, our office has the authority to research any matter that comes to the attention of the Advocate and advise or make recommendations to governments for improvement. Our office applies this child rights framework when fulfilling all functions of our mandate.

¹ United Nations General Assembly. (1989). Convention on the Rights of the Child. Geneva, CH: United Nations. (Retrieved from: <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>)

² Saskatchewan Advocate for Children and Youth. (2022). Guiding Principles. (Available at: <https://www.saskadvocate.ca/about-us/guiding-principles>)

³ UN General Assembly. (2007). United Nations Declaration on the Rights of Indigenous Peoples. A/RES/61/295. (Retrieved from: <https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html>)

⁴ First Nations Child & Family Caring Society. (2011). Touchstones of Hope for Indigenous Children, Youth and Families. Ottawa, ON: Author (Retrieved from: <https://fncaringsociety.com/touchstones-of-hope>)

Through this work, we are acutely aware of the barriers young people in Saskatchewan face in relation to accessing the services across the child-serving systems tasked with respecting, protecting and fulfilling their human rights.

1.2 Purpose of this Report

Each year, a significant number of children and youth access mental health and addictions services in Saskatchewan. However, many children cannot access the entire continuum of care required or never get connected to services at all. Despite the significant efforts by the system to address the gaps, there are roadblocks to services that are alarming when considering the needs of Saskatchewan children. There is a long way to go in ensuring the right of children to the highest attainable standard of health is met.

Our advocacy, investigations, and research into the matter of mental health and addictions services for children have shed light on the gaps and barriers to available and accessible services that have existed for over two decades. This dates back to a report under the then Advocate for Children and Youth, Dr. Deb Parker-Loewen, entitled, *It's Time for a Plan for Children's Mental Health*, (2004)⁵, which brought the systemic issues underlying mental health services for children and youth in Saskatchewan to the forefront. Some of these issues – the accessibility of services, the need for training and more mental health staff – remain prevalent today. A decade later, commissioned by the Government of Saskatchewan, Dr. Fern Stockdale released *Working Together for Change: A 10 Year Mental Health and Addictions Action Plan for Saskatchewan (2014) (MHAAP)* stemming from province-wide consultations with a range of individuals having direct experience with mental health issues. The recommendations, aimed at enhancing the mental health and addictions system, represent a valuable blueprint to benefit the people of Saskatchewan, including children and youth. More recently, our office released *Shhh...LISTEN!! We Have Something to Say – Youth Voices from the North 2017*⁶, examining the youth suicide crisis in northern Saskatchewan from a child and youth perspective, and hosted a youth-led mental health conference entitled, *Back Now in My Day: Our Issues, Our Voice, Our Time*,⁷ in 2019.

The impetus for this report is not only rooted in our work and extensive knowledge about the critical issues young people face that lead to poor child well-being but also in the historical context of several prior public reports, over the past two decades, on the persistent and longstanding gaps in systems for children. Many recommendations were made, over many years, to improve these systems. These include, but are not limited to:

- *Saskatchewan's Action Plan for Children – 1993* (Government of Saskatchewan);
- *National Child Agenda – 1999* (Joint Initiative/Federal/Provincial/Territorial Governments);
- *It's Time for a Plan for Children's Mental Health – 2004* (Office of the Children's Advocate);

⁵ Saskatchewan Children's Advocate. (2004). *It's Time for a Plan for Children's Mental Health*. (Available at: https://www.saskadvocate.ca/sites/default/files/pdfs/reports/cao_its_time_for_a_plan.pdf)

⁶ Saskatchewan Advocate for Children and Youth. (2017). *Shhh...LISTEN!! We Have Something to Say – Youth Voices from the North*. Saskatoon, SK: Author (Available at: https://www.saskadvocate.ca/sites/default/files/u11/listen_we_have_something_to_say_nov_2017.pdf)

⁷ For more information on the youth-led Back Now in My Day mental health conference, see our 2019 Annual Report, available at: https://www.saskadvocate.ca/sites/default/files/u11/2019_Advocate_for_Children_and_Youth_Annual_Report.pdf

- *Children First Principles – 2009* (Adopted by the Saskatchewan Government);
- *For Patients' Sake: Patient First Review Commissioner's Report to the Saskatchewan Minister of Health – 2009* (Commissioned by the Saskatchewan Government);
- *Child Welfare Review – 2010* (Commissioned by the Saskatchewan Government);
- *Saskatchewan Child and Youth Agenda – 2011* (Saskatchewan Government – later changed to Saskatchewan Child and Family Agenda);
- *Mental Health and Addictions Action Plan – 2014* (Commissioned by Government of Saskatchewan);
- *Shhh...LISTEN!! We Have Something to Say: Youth Voices from the North - 2017* (Saskatchewan Advocate for Children and Youth);
- *Pillars of Life: The Saskatchewan Suicide Prevention Plan – 2020* (Saskatchewan Government); and,
- *The Saskatchewan Strategy for Suicide Prevention Act, 2021* (Government of Saskatchewan).

These reports, plans, and strategies indicate the significant investment into the system of mental health and addictions and, while there have been investments, these have been pocketed and significant gaps related to wait times, accessibility, availability and coordinated and integrated services persist. The Advocate acknowledges the more recently stated record investments into mental health and addictions by the provincial government that have led to some critical and substantive changes since the MHAAP in 2014 that include but are not limited to:

- record monetary investments for the combined adult and youth mental health and addictions services in the 2019/2020 & 2020/2021 budgets;
- federal/provincial bilateral 10-year funding agreement to improve health care services including home/community mental health and addictions services;
- appointment of the first Minister of Mental Health and Addictions;
- commitments to suicide prevention including a Saskatchewan Suicide Prevention Plan, *The Saskatchewan Strategy for Suicide Prevention Act, 2021* and expansion of Roots of Hope;
- increasing access to mental health supports through the establishment of single-session, walk-in clinics in 23 communities, committing funding for Integrated Youth Services locations where young people can access multiple services in one place, increasing funding to Kids Help Phone and providing easier access for physicians to consult with psychiatrists on non-urgent cases;
- enhancing mental health supports in schools through piloting the Mental Health Capacity Building initiative in 5 schools and providing interim funding to school divisions following the COVID-19 shutdown for initiatives promoting positive mental health;

"There's too many of us. And we don't got time to wait."

- Youth



- supporting youth with high mental health needs in the community through funding to and creation of Community Recovery Teams in Regina, Saskatoon and Prince Albert;
- training for various professionals, including Mental Health First Aid training across sectors and CanREACH-SK Physician Training to increase physician comfort with assessing, diagnosing, and treating pediatric mental health concerns;
- increasing youth outpatient and inpatient addiction treatment beds with a new facility in Swift Current;
- mental health and addictions awareness campaigns;
- expanding crisis response through Police and Crisis Teams (PACT) and funding for future Urgent Care Centres in Regina and Saskatoon to provide an alternative to emergency rooms for non-life-threatening conditions; and,
- improving information sharing through provincial implementation of the Mental Health and Addictions Information System (MHAIS).



WHY WAIT?

The Advocate is encouraged that work has been done over the last two or more decades on this matter and the more recent investments. However, the current statistics continue to paint a grim picture, and with suicide still being the second cause of death amongst young people ages 15 -24 in Canada, the urgency by which the system needs to make the required changes cannot be overstated. Children are still waiting.



National Statistics

In Canada, children and youth aged 10 to 19 are more than **twice as likely** as any other age group to be hospitalized for **self-inflicted injury** ⁸

Suicide is the second leading cause of death among youth and young adults ⁹

Canada ranks **31st out of 38** rich countries in child and **youth mental well-being** ¹⁰

⁸ Public Health Agency of Canada. (2020). Suicide in Canada: Key Statistics. Ottawa, ON: Government of Canada. (Retrieved from: <https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-key-statistics-infographic.html>)

⁹ Ibid.

¹⁰ UNICEF Innocenti. (2020). 'Worlds of Influence: Understanding what shapes child well-being in rich countries', Innocenti Report Card 16. Florence: UNICEF Office of Research – Innocenti. (Retrieved from: <https://www.unicef.ca/sites/default/files/2020-08/UNICEF%20Report%20Card%2016%20Canadian%20Summary.pdf>)

Saskatchewan Statistics

The Saskatchewan Alliance for Youth and Community Well-being's Thriving Youth, Thriving Communities Report (2019)^{11 12} reported that of students in Grades 7 to 12:

38.6% reported **depressive symptoms** in the last year

21.6% reported having **engaged in self-harm** at some point in their lives, with 66% of those youth having self-harmed in the last year

23.4% reported having considered suicide in the past year, with **9.7% (977 youth)** having **attempted suicide** at some point

6% – 30% reported **binge drinking** (depending on grade level)

Drug use doubled, and cannabis use increased 6-fold from grade 7 to grade 12

Drug use was more **strongly associated with negative mental health outcomes** than with demographics such as age, gender, ethnicity, etc.

Less than half of youth who experience **depressive symptoms** (42.7%) or **considered suicide** (48.3%) within the last year reported ever having seen a therapist or mental health counsellor

1 in 3 youth (31.8%) who have self-harmed reported **not knowing where to go to get help**

Youth who experienced negative mental health outcomes were approximately **twice as likely to engage in high-risk behaviours** such as high-risk substance use, violence, carrying a weapon, and high-risk sexual activity

53.9% of youth who reported having **attempting suicide** in the last year **indicated they have seen a therapist or counsellor**

¹¹ Saskatchewan Alliance for Youth & Community Well-being. (2020). Thriving Youth, Thriving Communities Report – 2019 Survey Findings. (Retrieved from: <http://saycw.com/survey-and-findings/thriving-youth-thriving-communities-survey-2019-results/>)

¹² The Saskatchewan Alliance for Youth and Community Well-being (SAYCW) is a partnership between health, education and other community stakeholders dedicated to improving the health and well-being of the Saskatchewan population.



Data from the Coroners Service of Saskatchewan

- From 2010 to 2021, 235 children and youth aged 0 – 19 years died by suicide, with an average of approximately 20 suicides in this age group per year;¹³ and,
- From 2018 to November 2021, 9 young people aged 0 – 17 died as a result of accidental drug and/or alcohol toxicity.¹⁴

Co-occurring Mental Health and Substance Use issues

- 70% of hospital stays of Canadian children and youth for substance-related disorders involve a co-occurring mental health disorder. This is nearly double the proportion of co-occurring disorders among hospitalized adults.¹⁵

Impact of COVID-19 on Mental Health and Substance Misuse

- Young people in Canada aged 16 to 24 are more likely to report mental health and substance use concerns, and greater difficulty managing pandemic stress than the general population;^{16 17}
- 38% of children and youth in Saskatchewan report a decline in their mental health as a result of the pandemic;¹⁸ and,
- A majority of children and youth in Saskatchewan report that the pandemic has made changes to their lives that were “more bad than good”.¹⁹

Understandably, governments and priorities change, and this can impact initiatives geared toward children. However, there has been substantive regression in prioritizing children in the last several years and the government has lost sight of its goals for inter-ministerial coordination of children’s services set out in what was the Saskatchewan Action Plan for Children in 1993 and the subsequent Saskatchewan Child and Youth Agenda in 2011. The consequences have had devastating outcomes for children, and families are left to pick up the pieces.

The Advocate recently inquired with all child-serving ministries about the status of the Saskatchewan Child and Family Agenda. Unfortunately, there was limited awareness of this Agenda, nor was it noted as a top priority.

¹³ Saskatchewan Coroners Service. (2022). Suicides by Year, Sex and Age Group, Saskatchewan, 2005-2021. (Retrieved from: <https://publications.saskatchewan.ca/#/products/90866>) (NOTE: This is preliminary data as not all death investigations had been concluded at the time of reporting.)

¹⁴ Saskatchewan Coroners Service. Drug and Alcohol Toxicity Deaths for Ages 0-17, 2016 to 2021 (Gibson, S. Email to M Macomber. 19 November 2021)

¹⁵ Canadian Institute for Health Information. (2019). Hospital Stays for Harm Caused by Substance Use Among Youth Aged 10 to 24. Ottawa, ON: Author.

¹⁶ Canadian Centre on Substance Use and Addiction. (2022). Mental Health and Substance use During COVID-19: Spotlight on Youth [Infographic]. Ottawa, ON: Author. (Retrieved from: <https://www.ccsa.ca/mental-health-and-substance-use-during-covid-19-spotlight-youth-infographic>)

¹⁷ Statistics Canada. (2020). The Social and Economic Impacts of COVID-10: A Six-Month Update - Impacts on Youth. Ottawa, ON: Government of Canada. (Retrieved from: <https://www150.statcan.gc.ca/n1/pub/11-631-x/2020004/s9-eng.htm>)

¹⁸ Muhajarine, Dr. N. & Hinz, Dr. T. (2021). Preliminary results from See Us, Hear Us—Children, youth, and families in Saskatchewan coping with mental health during the first year of the COVID-19 pandemic (SUHU 1.0). Are the kids alright? Special Issue: Taking the Pulse of COVID-19 in Saskatchewan – in 7 charts. Saskatoon, SK: SPHERU & University of Saskatchewan

¹⁹ Ibid.

These are critical initiatives that prioritize child well-being inclusive of ensuring positive mental health and wellness. That said, our office is cognizant of the current focus and opportunity to improve the mental health system as both the provincial and federal governments are beginning to put more priority on mental health and addictions services.

Recent initiatives have the potential to address some of the concerns identified in the findings of this report, however, system change is slow. Although outside the control of the health system, the pressures of responding to the COVID-19 pandemic have further hindered the pace of these efforts. Improvements that have been made are pocketed and unable to reach all children who need them in a timely way. Over seven years have passed since the 10-Year Mental Health and Addictions Action Plan was released. Yet, the themed findings in this report reveal that several issues examined by Dr. Stockdale persist today.

Although this is the case, the Advocate acknowledges that at times young people do get good service and we know that at these times, when services align, it can go well. Some participants reported experiencing timely service, meaningful connections with service providers, comprehensive planning, smooth transitions, and positive outcomes. We also heard of innovative programs and initiatives that are bringing relief and hope to communities and the young people who live in them. However, it's clear this is not the norm, and most children do not have these experiences. We also know that there are good people working within a system that faces significant limitations. We must do better.

When we set out to do this work, we could not predict that a global pandemic would follow, disrupting every aspect of daily life. Although young people are exhibiting heroic resiliency in the face of the COVID-19 pandemic, the impacts of social isolation, school closures or moves to remote learning and job losses are causing stressors on many children, youth, families and communities. Research shows that young people across Canada are being hit harder by COVID-19 stressors than adults, with increasing symptoms of depression and anxiety and increased use of drugs.^{20 21}

In Saskatchewan, a majority of children and youth report that the pandemic has made changes to their lives that were “more bad than good” and 37% report a decline in their mental health.²² The collection of primary data from participants occurred before the onset of COVID-19, therefore our findings do not reflect the additional challenges created as a result. These circumstances only increase the urgency with which to address the barriers to meaningful services that existed before the pandemic.

Overall, our findings validate recommendations made in past reports and the Calls to Action in the Truth and Reconciliation Commission. While there are some unique recommendations arising from our findings, we hope that this report and its increased focus on the voices of children and youth will move the dial and ensure their rights to holistic health are respected.

²⁰ Canadian Centre on Substance Use and Addiction. (2022). Mental Health and Substance use During COVID-19: Spotlight on Youth [Infographic]. Ottawa, ON: Author. (Retrieved from: <https://www.ccsa.ca/mental-health-and-substance-use-during-covid-19-spotlight-youth-infographic>)

²¹ Statistics Canada. (2020). The Social and Economic Impacts of COVID-10: A Six-Month Update - Impacts on Youth. Ottawa, ON: Government of Canada. (Retrieved from: <https://www150.statcan.gc.ca/n1/pub/11-631-x/2020004/s9-eng.htm>)

²² Muhajarine, Dr. N. & Hinz, Dr. T. (2021). Preliminary results from See Us, Hear Us—Children, youth, and families in Saskatchewan coping with mental health during the first year of the COVID-19 pandemic (SUHU 1.0). Are the kids alright? Special Issue: Taking the Pulse of COVID-19 in Saskatchewan – in 7 charts. Saskatoon, SK: SPHERU & University of Saskatchewan

1.3 Situating Mental Health and Addiction in a Child Rights Context

Pursuant to Article 24 of the UNCRC, children and youth have the right to the highest attainable standard of health and access to health care services. As with any legislation, the UNCRC is to be read and interpreted as a whole. Article 6, therefore, elaborates on the interpretation of the right to health putting an onus on governments to “ensure the survival and development of the child to the maximum extent possible.” The child rights framework further articulates that “development” is meant to be seen as a holistic concept encompassing “the child’s physical, mental, spiritual, moral, psychological and social development” and directs that “[i]mplementation measures should be aimed at achieving the optimal development for all children.”²³ This holistic conceptualization of health is consistent with broader medical definitions that include positive mental health and freedom from problematic substance use.

World Health Organization

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. [...] Mental health is an integral part of health; indeed, there is no health without mental health.”

(<https://www.who.int/data/gho/data/major-themes/health-and-well-being>)

The Canadian Mental Health Association defines mental health as including our thoughts, feelings and emotions, feelings of connection to others and our ability to manage life’s highs and lows.²⁴ The simple presence or absence of a mental illness or disorder is not a predictor of mental health. A person without a mental illness could have poor mental health, just as a person with a diagnosed mental disorder could have excellent mental health.²⁵ Problematic substance use is seen by the Canadian Centre on

Substance Use and Addiction as the use of any psychoactive substances that results in problems at home, at school or in the community. Dependence or addiction is diagnosed when this pattern of use causes severe distress or impairment.²⁶ While problematic substance use can occur on its own, it often goes hand in hand with poor mental health when used as a coping strategy for untreated trauma, pain, challenging thoughts or emotions, or other health symptoms.²⁷ Conversely, substance use may cause or exacerbate mental health problems.²⁸

Therefore, in looking through the lens of “**optimal development for all children**”, threats to the enjoyment of the **overall right to health** posed by poor mental health and substance misuse can exist across a spectrum of symptoms, severity and impact, and are not limited to diagnosed disorders.

The child rights framework lifts responsibility for supporting positive mental health and freedom from problematic substance in children out of the sole realm of the health system. Human rights, and therefore children’s rights, are universal and inalienable.

²³ Committee on the Rights of the Child. (2003). General Comment No. 5 (2003) General measures of implementation of the Convention on the Rights of the Child. Geneva, CH: United Nations. CRC/GC/2003/5 (Retrieved from: <https://www.refworld.org/docid/4538834f11.html>)

²⁴ Canadian Mental Health Association. (2021). Fast Facts about Mental Health and Mental Illness. Toronto: Author. (Retrieved from: <https://cmha.ca/brochure/fast-facts-about-mental-illness/>)

²⁵ Ibid.

²⁶ Canadian Centre on Substance Use and Addiction & Ontario Centre of Excellence for Child and Youth Mental Health. (2013). When Mental Health and Substance Abuse Problems Collide. Ottawa, ON: Author (Retrieved from: <https://www.ccsa.ca/when-mental-health-and-substance-abuse-problems-collide-topic-summary>)

²⁷ Canadian Mental Health Association. (2021). Fast Facts about Mental Health and Mental Illness. Toronto, ON: Author. (Retrieved from: <https://cmha.ca/brochure/fast-facts-about-mental-illness/>)

²⁸ Watson, G., Carter, C., & Manion, I. (2014). Pathways to care for youth with concurrent mental health and substance use disorders. Ottawa, ON: Ontario Centre of Excellence for Child and Youth Mental Health. (Retrieved from: <https://www.cymha.ca/Modules/ResourceHub/?id=566257b1-a51f-493c-adcc-bd486492e236>)

“If you had better nutrition, we might see less anxiety. And if we had better access to healthcare services, we’d have less self-medicating as result. It’s a trickle-down effect, because the criminal justice system is really the end result of a whole series of systematic failures, right?”

- Judge

UNCRC Article 24
Access to Health
and Health Services

They apply equally to all children without discrimination and cannot be taken away.²⁹ Children’s rights are also interdependent and indivisible, meaning that if one right is not respected, it adversely affects the others.³⁰ Thus, children cannot fully realize their right to the highest attainable standard of health – including mental health – if they are experiencing racism, being abused or neglected, going hungry, lacking appropriate educational support and so on.

Therefore, any discussion of mental health and substance misuse must revolve around holistic notions of health and well-being and corresponding services to a child. Through this lens, we did not limit participant discussions to diagnosed mental health and/or substance use illnesses or disorders. Rather, participants were free to address concerns with mental health and substance misuse across the spectrum in acknowledgement that “optimal development” embraces the child or youth’s entire sense of well-being. There are references throughout this report to how every child-serving public system has a role in protecting, respecting and fulfilling children’s rights to the highest attainable standard of mental health. The need for systems to work together is central to the recommendations arising from our findings.

1.4 Scope of this Work

The scope of this work aimed to learn from children and youth about their needs to build and maintain positive mental health and well-being, and about their lived experiences in accessing and receiving mental health and addictions services.

We also gathered the perspectives of other stakeholder groups with knowledge and experiences with child and youth mental health and addictions services. These included parents/caregivers, frontline workers and management in the areas of health, education, justice, and child welfare, as well as community advocates, police officers, judges, and senior officials in all child-serving ministries.

In total, our office interviewed 491 people across Saskatchewan, including 135 children and youth aged 10 to 22 years old. Participants were from 28 urban, rural, remote, and First Nations communities across the north, central and south regions of the province. When connecting with First Nations communities, we ensured that Chiefs and appropriate leaders supported our work before meeting with youth in their communities.

Information was gathered from participants using semi-structured interviews, focus groups and written submissions. Discussions were centered around three research questions that were asked of all participants:

1. What has been working in the child/youth mental health and addictions system?
2. What barriers or challenges exist in accessing adequate and appropriate child/youth mental health and addictions services?
3. What are some suggested solutions for system improvement?

²⁹ Except in very specific circumstances in accordance with due process.

³⁰ United Nations Office of the High Commissioner of Human Rights. (2016). What are human rights? (Retrieved from: <http://www.ohchr.org/EN/Issues/Pages/WhatAreHumanRights.aspx>)

Number of participants in each stakeholder category	
Children and Youth	135
Parents/Caregivers	36
Health	146
Child Welfare	23
Education	83
Corrections	26
Community	31
Police/Judges	11
TOTAL PARTICIPANTS:	491

Our work adhered to the principles of youth engagement as set out by the United Nations Committee on the Rights of the Child,³¹ and to the ethical principles and guidelines for research under the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Human Participants*.³² This includes the use of informed consent, voluntary participation and confidentiality.

With the consent of participants, data gathered through these consultations were audio-recorded, transcribed, and analyzed using the Framework Method³³ to identify themes arising in response to the research questions. Secondary data was also accessed through our own work and other academic, government and technical publications to provide further context around the themes identified by project participants.

Direct quotes from participants, particularly young people, are illustrated to support the data being presented and accurately reflect the participants’ lived experiences. The findings were shared with the Advocate’s Youth Advisory Council and Elder Advisory Council for their review and feedback. Government ministries and health authorities impacted by the recommendations were also provided with an opportunity to review the findings and recommendations and make representation to our office.



³¹ United Nations Committee on the Rights of the Child. (2009). General Comment No.12: The Rights of the Child to be Heard, CRC/C/GC/12 Retrieved from: <https://www.refworld.org/docid/4ae562c52.html>
³² Canadian Institute of Health Research, Natural Sciences and Engineering Research Council of Canada & Social Sciences and Humanities Research Council. (2018). Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans. Ottawa, ON: Author. (Retrieved from: <https://ethics.gc.ca/eng/documents/tcps2-2018-en-interactive-final.pdf>)
³³ Gale, N. et al. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Medical Research Methodology, 13(117). (Retrieved from: <https://bmcmedresmethodol.biomedcentral.com/Articles/10.1186/1471-2288-13-117>)

While challenges to mental health and substance misuse exist across a wide spectrum and include many diverse symptoms and/or disorders, the types of mental health issues identified by stakeholders were primarily related to suicidal behaviour and self-harm, anxiety, grief, symptoms of depression and misuse of drugs such as crystal methamphetamine (crystal meth). As a result, the findings arising from our stakeholder consultations generally centre around challenges in accessing services to address these specific areas. This does not mean that other mental health and substance use disorders are not prevalent in our province. Although our analysis did not cover all facets of the mental health and addictions system, our office continues to monitor issues across the continuum of care.

1.5 Acknowledgements

Our office expresses the deepest gratitude to the children and youth and their families, who shared their experiences, challenges and successes in contribution to this report. We also thank the health professionals who shared their valuable expertise and on-the-ground knowledge of the system, as well as the other professionals and community advocates who provide support and encouragement to the young people they serve.



2.0

Overcoming Stigma: Better Understanding of Mental Health and Addiction Issues

Public knowledge and understanding of mental health and addictions issues is improving. The Advocate notes that since the release of the Mental Health and Addictions Action Plan in 2014, the province has expanded training in Mental Health First Aid across sectors to increase mental health literacy and capacity within human service systems. Many schools and community organizations are also doing their part. However, there is still a long way to go.

Youth participants reported persistent stigma and lack of understanding of mental health and addictions as a continuing barrier to reaching out for help. Young people described:

- fear of being judged;
- labelled;
- dismissed;
- hurt;
- losing friends if they change their behaviours around substance use;
- worry of having more barriers put in their way as a result of seeking help (ex. breaching probation conditions, having their own children removed);
- fears that service providers would not keep their information confidential; and,
- fears of opening up about their challenges and not having anything change.

Young people want continued and enhanced public education around these issues for themselves, their families, those who serve children and the general public. Youth described the need to feel safe enough to be vulnerable, be able to trust that adults will listen, and be confident that it will make a difference.

"A lot of smaller groups that I see are doing small initiatives to like stop the stigma. But I feel like everyone is still so afraid to talk about it."

- Youth



"It's hard to [open up to a therapist] because they have a life too and they have their own problems to worry about."

"I'm afraid the term 'suck it up' has done the most emotional damage than any other phrase to me."

"You're scared of the judgement, and you're scared of getting ridiculed. Growing up with the ignorance that I had from mental health or whatever, it felt like I was looking for people to pity me when, really, I didn't want that. I wanted people to understand and get me help."

"The people who don't suffer with mental illness – I feel they don't fully understand, because the people who don't go through what I go through every day just tell me to get over it."

"It's hard for me to talk about, because so many people have, like, frowned upon me I guess and said, 'Oh, why are you like that? You can just be happy.' Like, you'd think if I could be happy just like that, I wouldn't be sad all the time."

"I have known people in the past who have lots of access to tons of people they could talk to, but they just don't want to because they don't trust them. They don't trust that they could change anything."

"I feel they're just being paid to listen – that's the only reason they're here. [...] Do they honestly truly care about what I'm feeling?"

"Many kids don't trust them. [...] [My counsellor] told me everything was confidential. And then he told my mom everything that bothered me. And then that went absolutely brutal, so I stopped...I still was sent to the counsellor, but I stopped replying to them. [...] In the end, it just made my life worse."

"It is really difficult with parents, I find. [...] When [my mom] hears about these issues now, she is like, 'Get over it.' [...] I know you are tired of it – try living it. [...] I can't stop this, or I would have by now."

"You don't want to be the bother of the group. You want to be the fun one, the pretty one – you don't want to be the one that doesn't know how to party."

"I don't like burdening people with my burdens."



3.0

The Stories of Waylon and Jess

The stories of Waylon and Jess are highlighted here because several issues emerging from their circumstances are broadly represented within the themes of this report. In accordance with our legislation, and to protect the privacy of these youth and their families, the Advocate does not use their real names.

Waylon tragically died by suicide. Jess has experienced significant challenges related to her mental health and substance use, and along the way has encountered many barriers to accessing health services that meet her needs. In Waylon's case, our office conducted a full investigation inclusive of reviewing relevant documentation and interviewing staff involved in service provision. Jess's story surfaced during interviews with her and her caregivers. While we did not investigate her case, sharing her story through her eyes, as she experienced it, is illustrative of the many concerns raised by young people throughout the province.

Both Waylon and Jess faced deep struggles that, for Waylon, led to a devastating outcome – and ultimately, the violation of his right to life. Jess continues to work at maintaining her optimal level of health while experiencing ongoing barriers to services. Her rights to the highest attainable standard of health and access to appropriate health services were impacted by these barriers. Waylon and Jess may have had better experiences had the system worked more efficiently. Their stories provide a foundational understanding of what needs to change within the system of mental health and addictions services in our province.



3.1 The Story of Waylon

In March 2017, 16-year-old Waylon tragically died by suicide. When Waylon entered high school in grade 7, he struggled academically and was described as having a lack of confidence and motivation, requiring enhanced support and targeted strategies to assist him. Around this time, the school advised Waylon's parents that he was having thoughts of self-harm and his parents arranged for counselling. By grade 8, results from academic achievement tests indicated Waylon was two grades below his peers, however, the cognitive tests administered by a Registered Psychologist were not done. This was a missed opportunity to identify the barriers to Waylon's learning.

By grade 9, Waylon reported that he self-harmed to release built-up emotions. Waylon's parents took him to a mental health and addictions counsellor and advised the school that he was seeing the counsellor. At this point, a referral was made to connect Waylon to the school-based social worker. He attended counselling until January 2015 when his file closed citing that his situation had improved, and he reportedly stopped self-harming.

"Waylon was admitted to the adolescent psychiatric unit due to self-injury, suicidal ideation and depression."

In November 2015, Waylon was transported to the local hospital due to injuries to his wrist that required stitches. He was re-connected with the counsellor and a child psychiatrist. At the appointment with the psychiatrist, Waylon disclosed that he had suicidal ideation in the year prior and no previous suicide attempts. A psychiatric assessment was completed and shared with the family physician and the mental health and addictions counsellor.

A few days later, Waylon was admitted to the adolescent psychiatric unit due to self-injury, suicidal ideation and depression. At admission, he tested positive for marijuana. Several therapies and strategies were introduced to improve his mental health and he was discharged 15 days later. During this admission, there was evidence of conversations between the hospital psychiatric unit and school staff to discuss Waylon's mental health needs and safety planning strategies. Less than one week after his discharge from the inpatient unit, Waylon's parents transported him back to the hospital after he advised school staff of suicidal ideation. Waylon was not re-admitted to the adolescent psychiatric unit at that time as no beds were available.

In January and February 2016, Waylon continued to see the mental health and addictions counsellor to work on his treatment goals. His psychiatrist monitored his mental health and progress on medications. Waylon reported some success in reducing both his marijuana use and self-injury behaviour. However, when he did self-harm, his injuries were often serious enough to prompt the school staff to transport him to the hospital for medical attention. The mental health and addictions counsellor provided summaries of the sessions with Waylon to the psychiatrist and had contact with the school-based social worker and Waylon's mother.

In March 2016, the school called an ambulance after Waylon came to school with major cuts to his right forearm. He was subsequently admitted to the psychiatric inpatient unit. At this time, he received a diagnosis of major depressive disorder.

"Waylon came to school with major cuts to his right forearm. He was subsequently admitted to the psychiatric inpatient unit."

A multi-disciplinary team meeting was held with Waylon, his parents, school staff and inpatient staff to discuss the factors contributing to the increasing severity of Waylon's self-harming behaviour. The inpatient psychologist worked with Waylon and school staff to help him develop coping strategies and ways to reduce his urge to self-harm when he felt distressed. After seven days, Waylon was discharged. The discharge plan was discussed with Waylon, his family, inpatient staff, and school staff regarding the accommodation required at school. The unit staff also shared information with the family physician, psychiatrist, and the mental health and addictions counsellor.

Waylon's third and last admission to the psychiatric inpatient unit occurred in October 2016. Between admissions, there were instances where Waylon self-harmed. The school and Waylon's parents expressed concerns regarding their son's escalating drug use, school absenteeism, and suspension. He had admissions to a secure youth detox centre in May 2016 and an inpatient addictions treatment centre in June 2016.

After his discharge from the addictions treatment centre, Waylon reportedly did well with a couple of "slip-ups" and no signs of cutting or suicidal thoughts. Waylon advised the psychiatrist on August 12, 2016, that he was clean of drugs and had no problems with mood, anxiety, or his medication.

However, in the fall of 2016, the school reported concerns to Waylon's parents regarding his lack of school engagement and performance in school, conflict with staff, and possible drug use. In October 2016, Waylon was transported to the local hospital due to injuries on both arms and forearms. He was eventually assessed by psychiatry at the hospital and released to the care of his parents after he agreed to the safety plan. Ten days later, he was transported to the hospital again when he attempted suicide by overdosing on his medication. The family physician ordered a psychiatric examination under section 18 of ***The Mental Health Services Act*** and Waylon was transported to the hospital where a psychiatrist determined he should be admitted to the psychiatric unit, which he did, on a voluntary basis.

The psychiatric assessment completed at admission determined that Waylon's behaviour traits leaned more towards an evolving borderline personality disorder than his previous diagnosis of major depressive disorder. The treatment plan focused on Waylon learning skills to tolerate distress, practice mindfulness, and his medications were adjusted accordingly. In a meeting with the hospital psychologist, Waylon shared his feelings, which shed light on the pain he was experiencing. The psychologist noted that "...he feels angry and depressed almost all the time, but he feels the need to hide these feelings [...] he is skilled at hiding his depression even from his best friends and stated, 'I often paint a smile on my face.'"

When Waylon used marijuana on a pass home, his parents advised the hospital staff that he could not return home as his behaviours were too difficult to manage. Based on a referral to the psychiatric unit social worker, options such as section 10 services under ***The Child and Family Services Act*** and placement in a youth shelter were explored. The psychologist recommended family counselling and mandatory

drug testing to ensure sobriety. After 22 days at the psychiatric unit, Waylon was transferred to the secure detox unit for further intervention related to substance misuse.

When Waylon was discharged from detox in early November 2016, he and his mother met with a Ministry of Social Services youth services worker to discuss services available under section 10 of *The Child and Family Services Act*. When his mother requested a mental health group home for her son, the worker advised her this type of resource did not exist and the only resource the Ministry could offer was a short-term - under 30 days - emergency youth shelter. Waylon and his mother met the worker at the shelter where they reviewed the safety plan that was established earlier. At this meeting, Waylon's mother agreed to book Waylon's appointments at Child and Youth Services and to enroll him in school.

"When his mother requested a mental health group home for her son, the worker advised her this type of resource did not exist."

Waylon settled into the routine of attending school in the mornings and returning to the youth shelter in the afternoons to participate in the day program. In early December 2016, Waylon attended a series of appointments with the psychiatrist and the addictions counsellor. At his appointment with the addictions counsellor, Waylon reported no suicidal ideation in the two months prior, but before that, he had intense thoughts of suicide once or twice per month. When Waylon was at the youth shelter, the worker had multiple contacts with collaterals such as the school-based social worker, youth shelter staff, Child and Youth staff and his school.

In early January 2017, the youth services worker contacted Waylon's mother who agreed to have Waylon home on weekends in preparation for a potential transition home. During this time, Waylon self-harmed twice stating that he bottled everything up inside until he felt numb and needed a release. The youth services worker safety planned with Waylon, and the shelter staff monitored him accordingly.

On the day after the second self-harming incident, Waylon met with an addictions counsellor at the school and completed a suicide risk assessment. Waylon reported that he had no suicidal thoughts, nor a plan, and identified family, friends, and the future as reasons for living. Less than one week later, Waylon presented as under the influence, smelling of marijuana before leaving for a home visit. When confronted by the youth services worker, he denied using drugs. Waylon attended two more appointments with the addictions counsellor where Waylon reported that he was doing great and, at that time, no risks were identified.

At the end of January 2017, the pressure was mounting on the youth services worker to find an alternative placement for Waylon. Waylon conveyed he wanted to return home, and his parents decided to give him another chance. A discharge meeting was held in early February 2017, with Waylon, his parents, his youth services worker, and the shelter staff. The psychiatrist and addictions counsellor working with Waylon were not included in this meeting.

It was acknowledged that Waylon had been at the shelter for 93 days, over 60 days more than allowable due to the unavailable resources within Waylon's family or the

Ministry during this time. Waylon agreed to the rules of the family home, and the rules the youth services worker set out in the Preventative Services Agreement so services could continue. He signed a school contract outlining their expectations regarding attendance and the consequences of either using or being in possession of drugs.

Waylon agreed to complete a daily safety checklist regarding self-harm and medication.

Waylon had no further contact with the youth services worker between the time he returned home and the day of his passing. Waylon returned to school in mid February 2017. The principal noted that he was compliant with the contract, and he met with the principal daily to review the items on the checklist. Waylon did not show up for a meeting scheduled with his psychiatrist in mid March 2017, nor did he attend an appointment with the addictions counsellor scheduled around this same time. When the counsellor reached out to Waylon's mother one week later, she indicated that Waylon had expressed concerns regarding his sexuality which was the main reason he did not attend these appointments.

It was reported that Waylon managed well for a while after returning home, but in the days before he passed away, he threatened suicide on two occasions. Sadly, Waylon died by suicide shortly thereafter.

"Sadly, Waylon died by suicide shortly thereafter."

3.2 The Story of Jess

When we met with Jess, she was 17 years old. At birth, she went to live with extended family in a small, rural community in southern Saskatchewan, however, she eventually returned to her mother's care in an urban centre. While living with her mother, she experienced significant instability and emotional trauma, attending numerous different schools, and being exposed to addictions and domestic violence.

"She experienced significant instability and emotional trauma, attending numerous different schools, and being exposed to addictions and domestic violence."

Jess reports that she had contact with professionals during this time, such as the police, teachers, and counsellors who she felt could have better helped her and her family by intervening earlier. Jess believes this might have helped minimize some of her trauma and reduce her mental distress.

At the age of 15, Jess returned to live with her extended family who cared for her and did their best to support her. However, she was disappointed to be separated from her siblings. A sense of loss resulting from her severed family relationships, combined with her childhood trauma, contributed to her struggles with mental health.

Although she had been accessing mental health services to address these issues since elementary school, Jess faced barriers related to both the availability and accessibility of these services. There were no mental health services available in her home community, nor was there a counsellor at her school. The closest mental health service was over one hour away from her home. There was only one counsellor to serve all the youth in the area, causing long wait times between appointments. Appointments were only available during the day, forcing Jess to miss

school because of the travel time required to access services. Her anxiety made it difficult to attend appointments alone, but her caregivers are elderly and have their own medical concerns, which sometimes impacted their ability to assist her with travel. However, without their ongoing support, Jess could not get the ongoing treatment she needed.

The nearest hospital did not have a youth inpatient psychiatric unit. As a result, on one occasion when Jess was hospitalized due to mental distress, she stayed in an adult psychiatric unit where she says she was isolated in her room. She says the facility was not youth-friendly, and she describes her experiences there akin to what it might be like in a jail:

"I was the only young one in there with a bunch of older people and you just...it was kind of traumatizing 'cause I had to wear the same yellow pyjamas for seven days and nothing else. You weren't given anything else. And the first three days I was locked in my room. They brought me my meals on a cart, no T.V., no sound, just a clock. [...] I was just locked in my room and then I got markers one day for an hour. [...] I never even got to breathe outside air for seven days. I don't know if that helped me or made it worse. Because then I was just scared, 'cause I'm far from home and you can't have any of your own stuff. It's like jail, like literally, like jail. They take everything you have and then put you in a room with a clock and that's it. [...] I just felt like a criminal. And then I was embarrassed. [...] every day felt like years. [...] It was terrible. [...] I felt really alone."

Jess stated she was not included in planning around her care, did not understand what was going on, and had little access to her family during her hospital stay. The inpatient programming available to Jess was limited and she did not feel she learned any coping strategies to assist her after she was discharged. Her involvement with inpatient mental health services focused on stabilization and, from her view, lacked therapeutic treatment:

"I just felt like a criminal. And then I was embarrassed. [...] every day felt like years. [...] It was terrible. [...] I felt really alone."

"What they should do is they should take everything they're doing and do it the opposite way, because it's terrifying. Like, I can't even go on that side of [the city] anymore, because I'm scared I'm going to get locked up again."

Jess indicated she had been prescribed medication to help manage her anxiety. She expressed her frustrations with her psychiatrists, who she believed were quick to adjust medications without taking time to talk to her. After Jess attempted suicide, the doctors recommended her dosage be increased, however, discharged her before giving her time to adjust to the changes or further assess whether the new dosage would be effective. Jess reports she did not feel included in this process. Like many other young people in the same situation, she would like to have a voice in her medical care plan and be included in decision-making.

Over the years, Jess has worked with several mental health counsellors. Some of these experiences have created mistrust, leading to a lack of connection with the service provider. Her first experience with a counsellor was not positive. The counsellor shared what Jess disclosed during the session with Jess's stepmother despite telling Jess that their conversation would remain confidential. This made her already unstable home life even more problematic. She has also tried virtual addictions counselling sessions

"She feels like the adults and professionals supporting her talked about her instead of including her in discussions around what support she needed. She wishes there was a class on mental health in her school"

but felt she could not trust that the counsellor was alone and stated it is difficult to build a relationship without being face-to-face. While at times services were available, Jess reported she was not always able to get the support she needed.

At the time we spoke with Jess for this report, she had finally found a counsellor to whom she could relate and who she felt understood her needs. Jess indicated this counsellor's office was welcoming and comfortable, and that this person took the time to listen and get to know her. She described wishing that every prior experience would have been like this. Unfortunately, Jess was unable to meet with this counsellor as much as she would have liked. She had recently learned the counsellor was expected to take a leave and she did not know what this transition would mean for her treatment.

In addition to barriers related to accessing public services, Jess described being impacted by a lack of knowledge and awareness about mental health issues by individuals in her community. She feels people in small towns "don't really think kids down there have problems." Her view is that no one talks about mental health and the young people in her town do not know where to go for help. She believes people thought she was rude or selfish and stated that other kids made fun of her all because they did not understand her mental illness. She feels like the

adults and professionals supporting her talked about her instead of including her in discussions around what support she needed. She wishes there was a class on mental health in her school so that youth would know more about it, be more understanding of others and be more knowledgeable about how to meet their own needs.

Sadly, Jess's experiences accessing mental health and addictions services are not uncommon for Saskatchewan children and youth. Jess's childhood was filled with trauma. This, combined with a lack of preventative interventions and lack of availability to services, negative experiences with inpatient and outpatient care and the feeling of not being included in her planning further contributed to her mental distress. Jess is very fortunate to have had strong support from her extended family, who have committed to her care. For Jess and others like her, having access to adequate and youth-friendly mental health supports and services, both throughout childhood and into adolescence, would improve their ability to thrive and to reach their fullest potential.

4.0

Thematic Findings

Several themed findings emerged from our focus groups and interviews with stakeholders across the province identifying what works, what does not work and what participants identified as needed for a better mental health and addictions system. Unfortunately, we have learned that many of the gaps and barriers that have existed over the past two decades or more persist today. And, while the Advocate notes some pocketed investments, more is needed.

4.1 A Reactive vs. A Proactive System

It is well-known that the current approach to mental health and addictions is reactive, rather than proactive. The health system's available resources are primarily directed toward symptom reduction and maintenance instead of working to prevent the occurrence of symptoms before they become worse.³⁴

The consequence of this is reflected in the wait times and gaps in services experienced by children and youth across the province. Issues underlying or contributing to mental distress and substance misuse are, to a great extent, left unaddressed while an overwhelmed system scrambles to put band-aids on crisis points.

When it comes to what is working well in the mental health and addictions systems, participants – both internal and external to the health system – recognized that the barriers youth face are not reflective of the hard-working individuals providing service. Rather, their experiences are set against the backdrop of a system that is under-resourced and failing our youth through a lack of capacity to engage in prevention and early intervention.

"Health is doing the best they can with the capacity, design and set up that they got."

- Child Welfare

³⁴ This has been shown in SACY's 2004 report, *It's Time for a Plan for Children's Mental Health*, and again in the findings and recommendations of the 2014 *Mental Health and Addictions Action Plan*.

4.1.1 Lack of Prevention and Impact of Social and Environmental Factors

Young people in Saskatchewan often face multiple and complex challenges stemming from a variety of social and environmental factors. The negative impacts on the well-being of children resulting from adverse childhood experiences (ACEs) and inequities related to the social determinants of health are well-known.³⁵

Adverse Childhood Experiences (ACEs)

ACEs are potentially traumatic events that occur or aspects of a child's environment that can be traumatic and undermine the child's sense of safety, stability, and bonding. These include, but are not limited to, experiencing (or witnessing) violence, abuse, or neglect, and growing up in a household where there was substance abuse, parental conflict/separation or a family member involved in crime.

(CDC-2021). Adverse Childhood Experiences (ACEs). Retrieved from: <https://www.cdc.gov/violenceprevention/aces/index.html>

For Indigenous children, these challenges are exponentially magnified by intergenerational trauma resulting from past colonial and residential school policies. Yet, somehow, children, youth and their families still do not receive sufficient support to prevent these factors from leading to crisis.

With some exceptions, there was a general perception among the medical professionals treating these youth that much of their challenges were not related to their physiology, but rather to their social circumstances.

"I believe the majority of kids arriving with us are not mentally ill - or not significantly primarily mentally ill. They have that as part of a larger social issue. Which then raises the question for me, if the majority of children turning up in our emergency room are suicidal, coming from socially deprived backgrounds, are these appropriate referrals to specialized child psychiatry units?"

- Psychiatrist

"The majority of our cases are not psychiatry-related. It is a lot of social stressors. A lot of behaviour due to maladaptive coping skills."

- Psychiatrist

"It's not always a psychiatrist or a physician that is needed. It's often more basic things like community supports at the place of...the point of performance. At the point of where the kids live, schools, communities. There are the social determinants of health that have such an impact on why there will be higher incidences of difficulties in certain neighborhoods than compared to others. [...] It's very expensive to have a specialist see one child at a time and very relatively cheap to see lots of kids sooner and much less cost, not highly specialized medical professionals."

- Pediatrician

"Society isn't ready to hear how we're living out there. They look at things through privileged eyes."

- Elder Advisory Council

Participants identified a myriad of interpersonal and community issues that weigh heavily on the mental health of young people and can push or pull them towards substance misuse. Many of these challenges mirrored those identified by young people in our [2017 Shhh...LISTEN!! We Have Something to Say: Youth Voices from the North](#), which explored the contributing factors to youth suicide from the perspective of Indigenous young people. Although that project focused on the experiences of young people from northern Saskatchewan, our discussions with youth across the province for this report illustrate that many of the factors identified in *Shhh...LISTEN!!* are not confined to a certain population or geographical location. We encourage readers to review *Shhh...LISTEN!!* for a more in-depth understanding and discussion of those factors.

Social Determinants of Health (SDHs)

The model of SDHs used by Canadian researchers are a set of 17 indicators encompassing: general socioeconomic, cultural, and environmental conditions; social and community networks; and individual lifestyle factors. All have been identified as having an impact on the health and well-being of individuals. These include, but are not limited to disability, early childhood development, education food insecurity, housing, income, Indigenous ancestry, and social exclusion.

Raphael, D., Bryant, T., Mikkonen, J. and Raphael, A. (2020). Social Determinants of Health: The Canadian Facts. Oshawa: Ontario Tech University Faculty of Health Sciences and Toronto: York University School of Health Policy and Management. (Retrieved from: https://thecanadianfacts.org/The_Canadian_Facts-2nd_ed.pdf)

³⁵ Raphael, D., Bryant, T., Mikkonen, J. and Raphael, A. (2020). Social Determinants of Health: The Canadian Facts. Oshawa: Ontario Tech University Faculty of Health Sciences and Toronto: York University School of Health Policy and Management. (Retrieved from: https://thecanadianfacts.org/The_Canadian_Facts-2nd_ed.pdf) & Crawford, A. & Hicks, J. (2018). "Early Childhood Adversity as a Key Mechanism by Which Colonialism is Mediated into Suicidal Behaviour", *Journal of Northern Public Affairs*. 65, no.3

While not an exhaustive list of experiences and traumas that can lead children and youth to struggle, some of the issues identified by participants in this project include:

LACK OF COMMUNITY ACTIVITIES

"[T]here's not much going on in this community [...] they're just turning into drugs and alcohol instead of playing outside with their friends, enjoying their time."

-Youth

LACK OF HOUSING FOR FAMILIES

"If you're not in a stable home, you're not in a stable condition, then your mental health can get worse."

- Youth

LACK OF INDEPENDENT HOUSING FOR YOUTH

"More help with, like, homeless youth. [...] Like more shelters, maybe. [...] Like, counsellors too there."

- Youth

LACK OF EDUCATIONAL OPPORTUNITIES

"[I]n every First Nation school that I've taught at, the literacy and numeracy levels are very low."

- Education

LACK OF FAMILY SUPPORT FOR MENTAL HEALTH & ADDICTIONS ISSUES

"If you're too afraid to tell your parents, then I feel like that's the biggest barrier between you and getting help."

-Youth

POVERTY

"People always say to eat healthy. Because if you don't eat healthy, it affects your mental health and stuff [...]. Making healthy food more expensive than junk food doesn't send a good message."

-Youth

COMMUNITY VIOLENCE

"Violence is normal, we see it every day, it's just here. [...] What are we doing to address that in terms of mental health and addictions?"

- Health

GANG INVOLVEMENT

"They have no place to go so they go to a gang, where the gang can accept them...and that's what they want, to be accepted [...]. This is why we have so many gangs."

-Group Home Staff

LACK OF PARENTAL SUPPORT

"We're raising ourselves basically."

-Youth

ABUSE AND NEGLECT

"I realized that usually those who abuse children [were abused or have mental health issues] as well. But those mental health issues are things that can cause [...] It just creates a cycle, because then those children get depression, anxiety, trauma. And then they're screwed up for life too."

-Youth

LOSS OF COMMUNITY CONNECTION

"At the Band Hall, they have meetings and healings. [...] There are not as many now. [...] People don't show up. Some people participate and some don't."

-Youth

INTERGENERATIONAL TRAUMA/LEGACY OF COLONIALISM

"My addictions are what I'm dealing with it the most right now. And all of it stems from like residential schools – and, like, my dad going to residential schools and becoming an alcoholic."

-Youth

MENTAL HEALTH & ADDICTION WITHIN THE FAMILY

"Sometimes [the parents are] overwhelmed with grief, or their own mental health."

"[...] And a lot of our kids experience that they are the caregivers when the parents are dealing with addictions and their own mental health. [...] It's a lot of pressure. [...]"

They have to miss school because they have to look after the house."

-Education

BULLYING

"Kids judge kids. Kids are the harshest judges of the world."

-Youth

BODY IMAGE/LACK OF SELF-ESTEEM

"Models put out very negative image in – especially girls' – minds, that they have to be like that. [...] Like, if you don't look like that, then you're not worth it."

-Youth

INSTABILITY WITHIN THE CHILD WELFARE SYSTEM

"And then I was in foster care [...] since probably younger than five, and then I would be moving almost every year."

-Youth

PEER PRESSURE

"Addictions in youth are kind of normalized. I feel it's so normalized for teenagers to go partying and drinking and doing drugs every weekend, because they're having fun."

-Youth

LACK OF SUPPORT FOR LGBTQ2S+ YOUTH

"How do we help our young people who are [...] lesbian, gay, transgender, bisexual or two-spirited, right? [...] If you're not accepted for who you are, [...] how does that make you feel?"

-Health

Children and youth carry all these problems with them. Young people face substantial issues today, and the circumstances in which so many of them live place them at higher risk for mental health and addictions struggles. However, in the words of an Elder on the Advocate's Elder Advisory Council:



"The problem is so big. It's overwhelming at times. It's a huge problem. But just because it's big doesn't mean we should ignore it." - Elder Advisory Council

"[Y]ou can't expect anyone to make headway in terms of therapy if their basic needs aren't being met."

- Mental Health and Addictions

To support young people effectively, participants described the need for systems overall to better the social and environmental factors that are outside the parameters of the health system.

The health system, on its own, cannot address these systemic issues. Mental health professionals conveyed frustration at the expectation that they "have a magic wand" and can fix everything. To effectively address the root of much of the mental distress and addiction young people experience, there needs to be a coordinated, inter-ministerial effort. As children's rights are *interdependent* and *indivisible*, a child cannot realize their right to "the enjoyment of the highest attainable standard of health", as per Article 24 of the UNCRC, if their other rights are being violated – such as the right to be protected from all forms of abuse and neglect, or the right to an adequate standard of living. Therefore, governments and communities must find a way for child-serving systems to work together to create optimal environments where children can thrive.

It is recognized that some young people who experience some or all these factors do escape long-term impacts to their mental well-being despite their difficult life circumstances. Additionally, some youth in Saskatchewan experience complex psychiatric illnesses that are unrelated to the societal or environmental factors described here and require a medical approach.



4.1.2 Early Intervention

Early intervention is a critical part of a proactive system because it focuses on identifying and addressing the issues that lead to more serious mental health and addictions struggles, regardless of whether these are related to socio-environmental factors or rooted in physiology. However, the current system is set up in such a way that it does not have the capacity to engage in early intervention because the available resources are so overwhelmed dealing with youth in crisis. Due to this limited capacity (to be discussed in more detail later in this report) only the youth with the most acute needs (i.e., typically those who are actively suicidal or violent) are seen in a timely manner. This leaves a significant number of young people who desperately need support without services until they reach a crisis point.

"We're just finding that it's so time sensitive too. Like mental health isn't something that you can put yourself on the list and wait."

- Education

The Story of Waylon

Lack of academic performance and thoughts of self-harm were issues surfacing for Waylon when he was in Grade 7. This signalled the need for a process for Waylon, his parents, school, and counsellor to come together with a common goal of addressing the source of Waylon's struggles. Our investigation noted the importance of early identification and intervention to alleviate problems soon after they arise, so young people and their families are better supported.

"I find that usually the mental health is caught too late, and it isn't until you go to a hospital, in a psych ward, until things are actually done."

- Youth

"I think there's a misunderstanding in my view, that this is a teenage issue, that this is a high school issue, that it doesn't apply to younger kids. And I think that that is really where we're missing the ball. [...] We're in crisis mode by the time they get to us, it's Grade 7-9, whereas these issues are starting much younger than that, but they haven't come to head until they get to us."

- Education

"[The] current system is not preventative, it's a reactionary model. If you're not suicidal, psychotic, or incredibly struggling, you get a list of places in the community you could go – you could have just googled that."

- Mental Health & Addictions

"I would say there's sometimes a lack of kind of knowledge and understanding of the importance of working with children in early years to provide that early intervention and certainly try to support the family at a younger age. The time that it takes to do that is probably not something that we always have available with our waitlists."

- Mental Health & Addictions

"I wish it wasn't as judgmental, 'cause when one friend tried to call, because she wasn't contemplating suicide, she was kind of put on the back burner and it made things worse for her."

- Youth

"I feel like they don't take mental health seriously. [...] So, it takes literal people dying for it to become a big deal."

- Youth

"Another gap I think is in the prevention. Our staff are working full out all the time. And to be able to do that prevention piece of it, we don't seem to have the time. [...] I know all staff have it in their job descriptions to do prevention – and they do to a certain extent – but when you've got four or five clients a day...you're putting out fires."

- Mental Health & Addictions

"I feel for me that it just seems like they're waiting till something extreme happens before you get help or 'til your child gets older."

- Parent/Caregiver

"Nothing has been working well because we are being told our child does not "qualify" for services [...] because she is not self-harming or using drugs."

- Parent/Caregiver

“Proactive supports [are needed] rather than having to wait for failure before accessing services. When there has been a pattern and you can predict the future, intervention before failure is critical. Intervening early can save a lot of money for the system in the long term and a lot of heartache for the family.”

- Parent/Caregiver

The impact of a lack of early intervention ripples out beyond the health of the individual child. Staff in various sectors reported that if the needs of children are not met early on in their development, this can negatively impact the trajectory of their lives, resulting in potential trouble with the legal system, struggles at school or becoming involved in the child welfare system. Consequently, more proactive intervention at the earliest signs of need was identified as being required, rather than waiting for a crisis to occur or tragedy to strike.

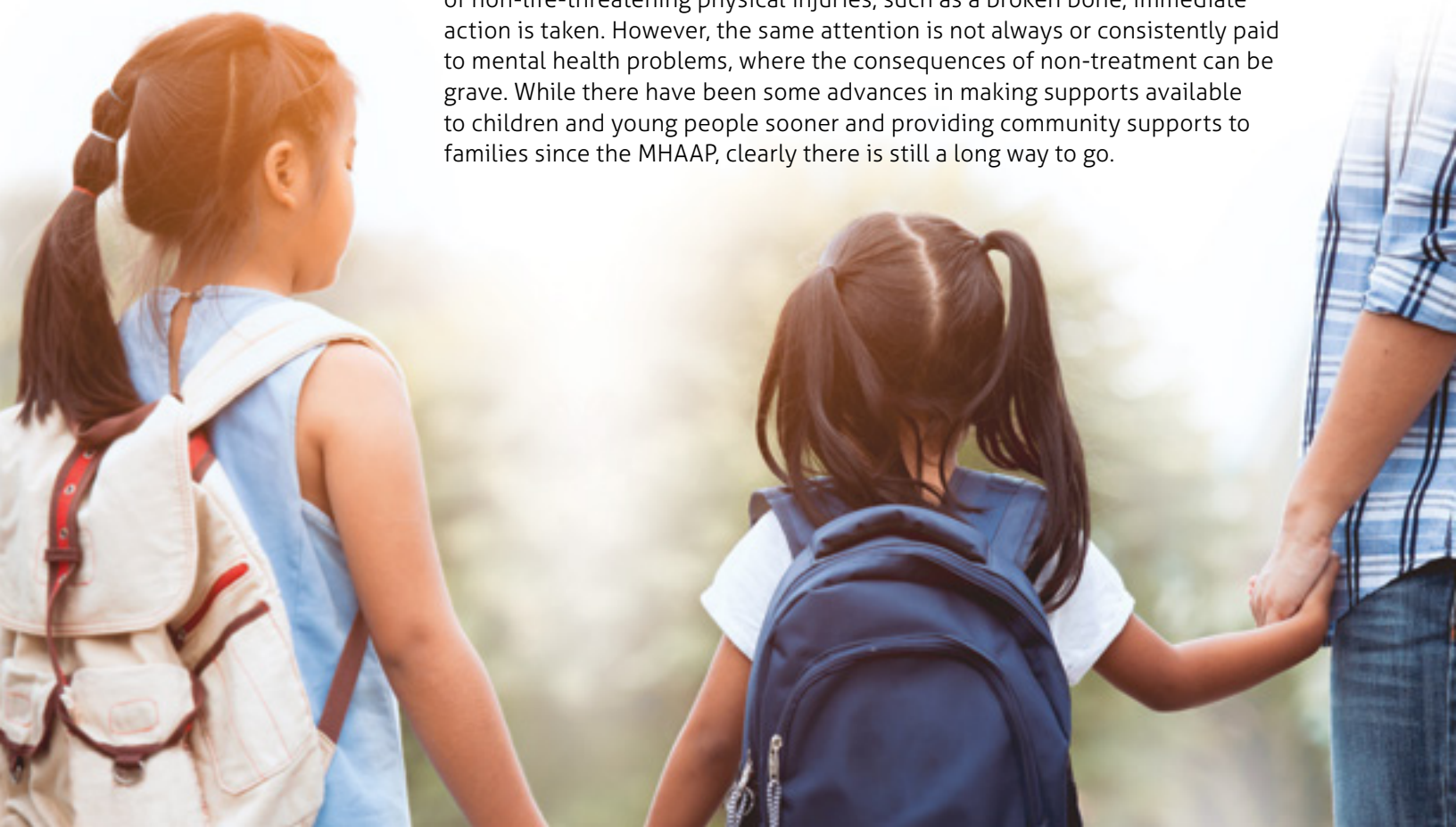
“There is not enough funding, or not enough people, and that’s where we’re missing the boat. I know many families where their kids should be in mental health [services], and they can’t get in, but these guys [in custody] get in first. That’s not right either. So, if those kids were helped on the outset, they might not have been here in the first place.”

- Corrections

“We want the support when they’re younger, and then time goes by and then next thing you know, they’re in Grade 6 and they don’t want the support. [...] If we could get the support obviously earlier on, maybe then it would change things going forward.”

- Education

These discussions highlight a discrepancy in the way physical and mental health and addictions issues are treated by the health system. In the case of non-life-threatening physical injuries, such as a broken bone, immediate action is taken. However, the same attention is not always or consistently paid to mental health problems, where the consequences of non-treatment can be grave. While there have been some advances in making supports available to children and young people sooner and providing community supports to families since the MHAAP, clearly there is still a long way to go.



4.2 Navigating Mental Health Services

In fulfilling the right of children and youth to the highest attainable standard of health, mental health and addictions services must be both available and accessible. For this project, we defined **availability** as **being the tangible existence of a service** and whether services and service providers were of **sufficient quantity** to provide timely service. **‘Accessibility’** is defined as **a child or youth’s ability to reach and/or meaningfully utilize an existing service**. These concepts are related and, at times, indivisible.

The need for services to be both available and accessible is affirmed by the UN Committee on the Rights of the Child, who directed in its *General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (Article 24)* that:

MHAAP System Goal: Focus on Prevention and Early Intervention

8. Build on existing programs that recognize the importance of healthy families and communities and positive environments for emotional development. [...]

9.2 Increase the availability of mental health and addictions clinicians for school-aged children for screening, assessment, and early interventions, especially in communities with greatest risk

At the primary level, these services must be available in sufficient quantity and quality, functional, within the physical and financial reach of all sections of the child population, and acceptable to all. [...] Secondary and tertiary level care should also be made available, to the extent possible, with functional referral systems linking communities and families at all levels of the health system. [...] States should ensure an appropriately trained workforce of sufficient size to support health services for all children.³⁶

Despite this direction, young people in Saskatchewan continue to face barriers related to the quantity and reachability of mental health and addictions services. Navigating these obstacles in the system can add to the distress children and youth are already experiencing.

³⁶ UN Committee on the Rights of the Child (CRC). (2013). General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (Article 24), 17 April 2013, CRC/C/GC/15, pp. 8. (Retrieved from: <https://www.refworld.org/docid/51ef9e134.html>)

4.2.1 Not Enough - Lack of Availability

The limited human resource capacity within the mental health and addictions system is a significant contributing factor to why it is a reactionary, rather than preventative, approach. The most common statement the Advocate heard from stakeholders is there are simply “not enough” services or service providers available to meet the needs of young people – not enough psychiatrists, psychiatric nurses, psychologists, community mental health nurses, community mental health and addictions counsellors, school counsellors, Elders, youth mentors and so on. Because there is not sufficient availability of service providers to meet the demand, youth who are not in acute crisis are often forced to wait for service – sometimes for unacceptable periods of time, and sometimes never receiving service at all.

“We’re lining up to ask for help – and there’s a lot of kids there that need it.”

- Corrections

“The need is greater than the services that are available. So, I think what we see is a barrier or a gap is that access to timely service and the right service.”

- Child Welfare

4.2.1.1 PSYCHIATRIC CARE

“I don’t even know if there’s enough accessibility to psych nurses, let alone psychiatrists or those types of things. I think that there are lots of things available for somebody who might have a sprained ankle or a hurt knee. But somebody who might be dealing with anxiety or maybe depression? I don’t necessarily know the same supports are there.”

- Community Mental Health Advocate

Currently, there are 19 child and adolescent psychiatric specialists providing services in Saskatchewan on either a fee for service or contract basis, with two additional psychiatrists scheduled to begin their work within months of this publication.³⁷ The Saskatchewan Health Authority’s goal is to meet triaging targets for child psychiatry 50% of the time. Information provided by the Ministry of Health indicated that, as of August 2019, the wait time for non-urgent child psychiatry was approximately four to five months in Regina and one year in Saskatoon.³⁸ Due to concerted efforts made by the health system, this was a significant improvement to the two-year waitlist previously faced by young people in the Saskatoon area. However, there is still a gap in the system with too many children waiting too long for service. In Prince Albert in 2019-2020, while triaging goals were being met for children assessed as severe or very severe, these were not met for 90% of children with mild to moderate acuity. These children were waiting more than 20 business days for their first appointment with a psychiatrist.³⁹ Access to child psychiatry in Saskatchewan has been a longstanding issue that dates back at least two decades⁴⁰ and remains unresolved.⁴¹

“There are almost 800 kids on the waitlist to see a child psychiatrist in Saskatoon. Literally every month we fall further behind, because we get more referrals every month than we have the capacity to see.”

- Psychiatrist
(quoted in Saskatoon
Star Phoenix,
21 Aug 2021)

³⁷ Email Communication from official and DM of Ministry of Health to Advocate for Children and Youth, February 2022 and March 2022.

³⁸ Email Communication from Ministry of Health to Advocate for Children and Youth, 19 August 2019.

³⁹ Provincial Auditor of Saskatchewan. (2021). Report of the Provincial Auditor to the Legislative Assembly of Saskatchewan: 2021 Report - Volume 1. Regina, SK: Author.

⁴⁰ The Saskatchewan Children’s Advocate Office. (2004). It’s Time for a Plan for Children’s Mental Health. Saskatoon: Author. (Available at: https://www.saskadvocate.ca/sites/default/files/pdfs/reports/cao_its_time_for_a_plan.pdf)

⁴¹ Vescera, Z. (2021, August 19). Saskatchewan’s chronic psychiatrist shortage is costing lives. Saskatoon Star Phoenix. (Retrieved from: <https://thestarphenix.com/news/saskatchewan/saskatchewan-chronic-psychiatrist-shortage-is-costing-lives>)

“The skill set is aligned mostly in cities. Whereas need is mostly [...] well, it’s all over the place.”

- Psychiatrist

“There’s too many of us. And we don’t got time to wait.”

- Youth

The few child psychiatrists the province does have are concentrated in the larger urban centres, leaving many communities with no access to psychiatric services in their hospitals, and making it even more difficult for a young person to access appointments when issues arise. Although itinerant psychiatrists are travelling to northern communities, stakeholders indicated that in the North that this needs to happen more often to meet the existing demand.

While virtual access to adult psychiatrists through Telehealth is an option in some rural communities, stakeholders reported that some professionals have not been open to meeting with youth in this way, citing that treating children is not their specialty.⁴² Stakeholders in smaller cities indicated that psychiatrists in larger centres want patients to be treated in their home communities. However, the only options for this are family doctors, many of whom will not prescribe or adjust psychiatric medications.

Acknowledging that not all children and youth with mental problems require psychiatric care, stakeholders reported that the lack of available child/youth psychiatrists resulted in some youth who required service never being connected at all.

“It took me being in the hospital, almost dead, for [the psychiatrist] to, like, notice me I guess and take my case.”

- Youth

Stakeholders identified several other ways in which this lack of resources negatively impacts the well-being of children and youth, including:

- long waits in emergency rooms when youth are in crisis;
- lengthy waitlists for outpatient services resulting in youth experiencing crises and ending up in emergency rooms;
- significant lengths of time between outpatient appointments;
- difficulties accessing a psychiatrist between appointments if a crisis arises or medications need to be adjusted; and,
- increased stress on families/caregivers and other child-serving systems trying to support the young person.

Concerns were also raised that large caseloads resulted in insufficient time spent with each patient and appointments focused solely on medication management. Stakeholders conveyed this brevity does not allow the psychiatrist to adequately consider treatment options to address the root cause of the problem which, often, is trauma. This leaves youth feeling rushed and unheard. Clinicians also share this concern, stating young people require more appointment time than adults and time constraints compromise patient care.

“[L]ife just spirals. They get worse.”

- Parent/Caregiver

⁴² Also see section on “Outreach” for a further discussion of virtual services.

“Skill task alignment is key here. You really want to affect change in a child – you need good psychologists all over the place.”

- Psychiatrist

“They’re just thinking, ‘How can I make this quickest for both of us to get out of here?’ And then you, like, miss things and forget to tell this one thing. And then, I don’t know [...] and then when you’re okay, they say, ‘Okay, I’ll see you in 6 months.’ Like, yeah, I’m good. I’ve been doing good. I’m taking my meds. And then they’re like, ‘Okay, I’ll follow-up in 6 months’ and see how I’m doing then. But then, in those 6 months, I could try to kill myself again. If there were, like, more doctors, there would be more treatment for people and more quality treatment.”

- Youth

“You heard of that ‘one visit, one problem’ thing? Psychiatry patients are...I don’t know of any that have one problem. It’s chronic management. [Another participant: And you can’t do it all in six minutes. Not well, anyways.] They often multiply co-morbid – with not only medical issues, but multiple psychiatric social issues – so it’s a chronic medical care model rather than a [...] [Another participant: Yeah. That’s a barrier.]”

- Psychiatry/Pediatrician Focus Group

The health system has acknowledged the wait times for child psychiatry, the difficulty with recruitment and retention and the need for improvements. However, these circumstances must be viewed against the backdrop of what has been described as a global shortage of child psychiatrists. While incentives are provided to eligible specialists to practice in Saskatchewan,⁴³ stakeholders questioned whether the province had a sufficiently vigorous recruitment strategy, inclusive of dedicated staff and appealing compensation packages.

We understand from health officials that there have been varied efforts to address the issue, such as hiring an additional child/youth psychiatrist and a triage nurse to assess the waitlist. In some communities, psychiatric nurses connect with patients between appointments to support medication monitoring, answer families’ questions and bring other questions to the psychiatrist. We also learned that the health system has made efforts to employ other creative means to make psychiatric services accessible through primary care physicians.

One initiative called CanREACH⁴⁴ allows physicians to access voluntary training to increase their comfort with – and compensation for – assessing, diagnosing and treating pediatric mental health concerns. As of January 2022, 146 physicians, general psychiatrists, nurses and medical students had taken this training since its inception in 2020.⁴⁵ Additionally, family physicians can now access real-time psychiatric consultations for non-urgent cases via telephone through LINK (Leveraging Immediate Non-Urgent Knowledge) (a.k.a. The Virtual Physician Lounge).⁴⁶ An average of 18 calls per month are made to psychiatrists using this service.⁴⁷ As a result of these initiatives, physicians are potentially able to address youth’s concerns and avoid referring them to a psychiatrist or sending them to an emergency room. However, these programs are relatively new, and their long-term impacts are yet to be seen. There were concerns expressed by specialists that the CanREACH model will only work when combined with good, stable primary care which is viewed as challenging in rural areas where there is a high turnover of physicians.

43 Saskatchewan Medical Association. (2020). Specialist Programs. (Retrieved from: <https://www.sma.sk.ca/programs/38/specialist-programs.html>)

44 <https://cmelearning.usask.ca/current-courses/the-reach-institute.php#CanREACHSKPatientCenteredMentalHealthinPediatricPrimaryCarePPPMiniFellowship>

45 Email communication from Ministry of Health to Advocate for Children and Youth 2 February 2022

46 <https://www.ehealthsask.ca/services/Referral-and-Consult-Tools/Pages/LINK.aspx>

47 Email communication from Ministry of Health to Advocate for Children and Youth 2 February 2022

4.2.1.2 PSYCHOLOGICAL CARE

We know that much of the mental distress experienced by young people today can be traced back to social and environmental – rather than biological – factors. Many in the health care field indicate that having more psychiatrists is not the sole answer to a deeply entrenched problem. Rather, more support is needed for psychological and social supports that will contribute to the overall mental health and well-being of children and youth.

It was suggested that if psychologists collaborated with family physicians who were trained to prescribe and adjust psychiatric medications, “that’s a team that could do a lot of stuff that a child psychiatrist would do – if they only worked together.” (Psychiatrist)

Publicly-funded psychologists can be found in both the health and education systems – and both systems are under-resourced in this area. As with psychiatry, health system officials acknowledged that recruiting and retaining psychologists has become very difficult as many are migrating to private practice. Consistent with all specialist services, access to psychologists becomes even more difficult for children and youth in rural areas. Concerns were raised that this results in different levels of service to youth depending on residence.

As child-serving systems – such as justice and education – rely on psychologists to conduct assessments for violence, behavioural concerns, cognitive functioning, learning disabilities, and so on, delays caused by a lack of specialists can impede the ability of these systems to serve children effectively and have devastating impacts on the life trajectories and prospects of success of vulnerable young people.

Forensic child psychologists able to provide advice to the court regarding the sentencing of youth involved in the justice system are hard to find. This can result in delays in moving a youth’s court matters through the system in a timely manner, thereby impacting their case planning, and (if incarcerated) their reintegration efforts. We also heard that when psychologists are pulled to conduct court-ordered assessments, it often means services to other youth who require these are delayed.

“In the life of a kid who needs timely intervention, if you get a report three or four months later, the kid’s behaviour is continuing to spiral out of control. It doesn’t help as much as it could have if it had been earlier, right?”

- Judge

“Even when we’re going through the court systems and kids are waiting to get these assessments done, in the meantime, they’re sitting in remand and they’re not getting any support as well.”

- Corrections

"There's one psychologist in the province who [specializes in LGBTQ2S+ issues], who is amazing. Like, she's incredible, but she also does a lot, and so, you know, one person can't service an entire province. But then we see it on our end when the youth is spiraling and not getting the supports that they need."

-Corrections

Participants across stakeholder groups also identified a lack of psychologists working within the school system as being particularly detrimental to young people. When psycho-educational assessments requested by schools are delayed, students cannot access necessary classroom supports or specialized programs. These circumstances can, ultimately, impact the young person's attendance and academic success.

"So, in total, I have 2000, about 2200 [students], I think. And when you look at the number of kids that school psychologists – what it's thought to be – it should be between five to eight hundred, depending on the kind of schools that you're at – for school psychologists."

- School Psychologist

"It's so challenging to see a kid just, you know – every day – not be able to get out of the vehicle, but because we can't get that paper, we can't put them where they belong."

- Education

Once children do receive psychological assessments, participants reported difficulties with accessing follow-up services with a psychologist or other service provider after diagnosis. For children continuing to experience significant highs and lows, parents are being told to "go private". Concerns were expressed that there was a "two-tier system", wherein families with benefits or sufficient income allowing them to access private psychologists may receive much timelier service than those who rely on the public system.

"You're stuck with me, and you won't even know when you get to see me and that's got to be hard for families. [...] And I worry that what I see happening is that two-tiered system of mental healthcare for children and youth."

- Psychologist (public system)

Access to benefits for private therapy is even less likely for young people who are living independently and may be disconnected from their families, as youth typically do not have the type of employment that offers them. However, even in circumstances where youth have access to private services – whether through private pay, employment benefits, First Nations and Inuit Health Branch or as a result of involvement with the child protection or justice systems – there can still be significant wait times.

"As you get older, you are kind of more on your own, you are more independent. And if you try to go to a therapist that will cost money and, like, some people probably won't have the income or like have enough money to afford a therapist so they will kind of be left alone. Kind of like on their own island. Left stranded."

- Youth

"We've been starting to pay for a lot of services to try and fast track our kids and now our paid-for services are overloaded and so we can't fast track our kids. So, you know, before, it used to be that you could pay for something, and you wouldn't have a waitlist but now [...] You can't even do that anymore."

- Child Welfare

The limited number of child psychologists also means that there often is not a service provider accessible who specializes in the type of therapy most appropriate for a young person. We heard of unmet needs for access to specialists in youth trauma, play therapy, music therapy or pet therapy. A significant gap was noted in psychology services appropriate for LGBTQ2S+ youth. This lack of diversity was also noted in the 2014 Mental Health and Addictions Action Plan, which recommended enhancing the responsiveness of services to diverse groups.

"I've only been doing this for 14 years, but the types of kids that are coming on to our caseload are so much more complex and the family dynamics are more complex, so even the case management that comes with it [...] I mean you've got higher caseloads and the caseloads come with case management that is just through the roof. There's no way we can be everywhere that we need to be."

- Mental Health and Addictions

4.2.1.3 MENTAL HEALTH AND ADDICTIONS COUNSELLORS

"It took me a really long time to get a counsellor."

- Youth

Like the shortage of psychiatrists and psychologists, we also heard concerns around the availability of community mental health and addictions counsellors. In many regions, stakeholders reported that young people had to wait what were perceived as unacceptable periods of time to be assigned a counsellor.

"I feel like it takes too long to get the help that you need, because when you're trying to look for a counsellor that can help when you're upset, that you can just call to make an appointment [...] I feel it takes too long to get a counsellor to help you."

- Youth

"When you seek out a counsellor, you're usually going through some sort of crisis, right? The youth is. And every time it's always been – like, the first time I ever got him trying to get a counsellor, it was like a three-week wait. So, what do I do until then?"

- Parent/Caregiver

"Everybody's waiting for counselling."

- Community Organization

There is no disputing the need to prioritize service provision to children and youth with higher needs. The Advocate acknowledges data from the Ministry of Health indicating that provincial triaging targets are met in most areas of the province, with very few exceptions. However, wait time data was not available for Regina or Saskatoon.⁴⁸

Despite this, young people and other stakeholders believe these targets are unreasonable. Youth report needing less of "a gap between when you want to request [help] and when you actually get it", and "enough workers [...] so that everybody can get in".

Many frontline staff shared these concerns, stating that making youth wait for service compromises their ability to engage in early intervention and increases the acuity of youth's symptoms.

"And then we have to prioritize. So then, what we do is we triage ones with the highest needs – complex cases first – and, unfortunately, the ones that are not seen in that light end up waiting for services and then they end up, usually, needing the services down the road because they've been triaged-up. So, that's a vicious circle for us."

- Mental Health and Addictions

Provincial Triage Categories for Mental Health & Addictions Outpatient Services

Very Severe: Clients seen within 24 hours

Severe: Clients seen within 5 working days

Moderate: Clients seen within 20 working days

Mild: Clients seen within 30 working days

"They need to know what to say to get them help as they need it. [...] Saying 'Well, sometimes they say they think about hurting themselves' [...] they may not get that service tomorrow or today, it might be a week or two down the road and I don't know if that's going to be fast enough."

- Community Mental Health Advocate



It was also reported that counsellors' overloaded schedules do not allow flexibility to adapt to the constantly changing needs of young people. Youth and other stakeholders expressed frustration that young people are not able to speak with their counsellors on short notice when things are not going well, or re-book in a timely manner if they are unable to attend a scheduled appointment.

"Like, the thing I notice about counsellors and stuff – they're never really there when you're feeling bad. 'Cause it's like, I have an appointment this day, but by the time I get there, I'm feeling fine now."

- Youth

Stakeholders acknowledged that youth have the option of calling a crisis line or Healthline 811 for more immediate service and, in some larger communities, can access free, single-session, walk-in counselling. However, while helpful, these services require young people to talk to someone unfamiliar and re-tell their story from the beginning each time and do not provide the stability of ongoing support that youth are looking for.

Another reported concern was the lack of service provision in rural and northern communities. Although mental health and addictions counsellors do travel from several "service hubs" to some surrounding communities, stakeholders – including health staff – did not feel that this was enough and wanted to see services provided in more rural communities.

"Fifteen years ago, we'd travelled to multiple communities and serve the rural areas. I feel like, I would say probably 10-15 different communities we were travelling to. Currently, we travel to 3. So, we've really cut back rural services. [...] So those rural communities really aren't being served or they're having to come to kind of like a hub to be served. I mean we are trying to serve them in other ways, like maybe through telehealth and things like that, but again, there are some barriers to access that because they would have to be in a location where that is available, right or it has to be certain times."

- Mental Health and Addictions



"I think, too, we really try and make up for that through like free resources, like, there's counselling at the library, there's counselling lines through Canada Health phone. Like, we use a lot of crisis text lines sometimes too. But again, it's [...] most of the time they're doing this when they're really at a tipping point. Not like, you know, 'I'm seeing my counsellor every two weeks. Things feel fairly okay.' But sometimes they've gone to the free counselling at the library and it's like a huge waitlist, or can't really get in to see them at that time and then it'll kind of come back and feel bummed out 'cause they didn't get in."

- Community Organization

Stakeholders in northern communities with itinerant counsellors indicated having service providers in the community anywhere from twice a week to once per month is not sufficient. Northern youth reported that the clinic is "always packed", that the demand for service is so high that "you have to wait until it's a real problem" and that, when they finally "feel like [they] have the courage to actually say what [they are] feeling inside, there's nobody to talk to."

When it comes to addictions services, youth stated that when there are not enough supports in their community, maintaining the progress made during inpatient treatment can be difficult:

"It is definitely difficult to keep it up coming back into the community. [...] You really have to change a lot of your lifestyles. You are trying obviously to stay sober and, in my opinion, especially trying not to use. But everything down to music, to the smell of certain foods can trigger you [...] so having more supports like that in our actual community would be I think personally better."

- Youth

It is noted this deficit is often the result of difficulties recruiting qualified workers to rural and remote communities. Even if there are funds available for staff positions, system officials report not getting applicants, resulting in lengthy vacancies, and many young people being left without service.

The Advocate acknowledges the efforts being made to increase investments in mental health and addictions services in some communities. However, continued resource investments would not only reduce wait times for patients but would also decrease burnout in staff of all child-serving systems.

4.2.1.4 SCHOOL COUNSELLORS

School counsellors and other mental health supports in the education system were identified by stakeholders in every category to be a necessary service to children and youth. Having counsellors in the school was described as desirable because "they [are] just there" and provided more immediate, onsite support for youth. In-school counsellors are also familiar with the youth and aware of what is going on at school, which is the environment where young people spend most of their time.

"When we do get to crisis, then you cannot see any of those other kids. Because we end up in crisis so much – because we only get so much time. So, we must put out those fires – so, the other kids move lower down the list and not because [...] it's through no fault of...like, it just doesn't work. There's just not enough time."

- School Counsellor

However, a shortage of mental health providers in schools was identified as one of the most common barriers to accessing mental health support – some youth reported their schools did not have access to a counsellor at all. In other areas, counsellors employed by school divisions split their time between several schools, meaning their time in each location was limited or sporadic. Even in those schools

fortunate enough to have dedicated counsellors, we still heard there were not enough to meet the needs of the students. Stakeholders also reported that academic counsellors whose intended role is to provide behavioural support and academic guidance are frequently spending much of their time supporting youth in emotional crisis. We heard from youth who indicated that any extra support was only brought into their schools when there was a significant event or trauma, but that young people needed this level of support all the time.

"We don't even have a counsellor anymore. We don't have anything. School is probably the worst place."

- Youth

"I like working with [the school counsellor] too. I've only talked to her a couple of times. I find that the biggest problem though is she works for three schools, so she's not always here for the littler things. So, that's kind of tough."

- Youth

"I know in my school we only have two counsellors which can also be a barrier, because [...] they're usually booked up for quite some time. And so, I know that when my grandma was getting sick and stuff, I needed someone to talk to. [...] I know this is going to be a long type of sadness instead of just a...kind of thing. But I just wanted to talk to one of the school counsellors and it was so hard to try and get an appointment, because there's so many kids in the school."

- Youth

"In looking at it based on – not only need – but numbers, I have two [counsellors] for 500 kids – that's not sufficient. So, even if 40% of those kids have issues they need to talk about, that's still a huge amount of kids per counsellor."

- Principal

"And they only started really getting influenced onto like helping the mental health – but that only was for the three days and then everything went back to normal. It's kind of just been dismissed now. It's been just like, yeah, another incident [suicide] out there, unfortunately. So, if we could have that support every day, then that would probably be one of the factors to lessen the statistics."

- Youth

Demand for services in schools is so high, educators reported having to engage in the same triaging as the health system. As a result, their available resources are spent managing high-needs cases, and students with less invasive behaviours are left without support. Consequently, the needs of these students increase while waiting, impeding the fulfillment of their right to education and impacting the educational experience of others around them.

Just as wait times for specialists and community counselling negatively impact classrooms, in turn, when less acute needs cannot be addressed by the school, acuity increases, and more pressure is put on the health system. To meet the day-to-day needs of young people and prevent the need for intervention by the health system, stakeholders called for:

"She knows my older brother, she knows my family, that's why she knows what I've been through throughout my life. So, that's why I go to her when I'm in school."

- Youth

- at least one mental health counsellor in each school, and more where the student population requires it;
- mental health supports in elementary schools to provide early intervention and prevent students' risk from increasing over time; and,
- increased access to Elders and Knowledge-Keepers.

These recommendations are not new. The need to increase clinical mental health supports in schools was identified in the recommendations of the **Mental Health and Addictions Action Plan** in 2014. Unfortunately, since this time, participants have described cutbacks, rather than increases, in these resources. We learned the government did develop a one-year interim plan to provide additional funding to school divisions to support the promotion of positive mental health as children returned following the COVID-19 shutdown.⁴⁹ This step was positive considering the toll the pandemic took on the mental health of children and youth. However, the need for sustained investments in this area remains.

MHAAP System Goal: Focus on Prevention and Early Intervention

- 9.** Deliver programs and services that promote better emotional health for children and youth in schools and other places where they spend time. [...]
- 9.2** Increase the availability of mental health and addictions clinicians for school-aged children for screening, assessment, and early interventions, especially in communities with greatest risk.

⁴⁹ Government of Saskatchewan. (10 August 2021). Media Release – Government of Saskatchewan Provides Additional Supports for Students this Fall. Regina, SK: Author. (Retrieved from: <https://www.saskatchewan.ca/government/news-and-media/2021/august/10/government-of-saskatchewan-provides-additional-supports-for-students-this-fall>)

"A student has a need, and we don't have to make forty phone calls and then wait four hours, and then – and then go there. When a student says, 'Hey, I could come and talk to someone right now', that's refreshing."

- Education

"I think when the cuts were happening, especially the school counselors, there was no thought to how that would impact other service sectors like Health – so Child and Youth [Services] has had to absorb a lot of services that would have been happening within the school. So, not only are they seeing clients that may be blowing up and they're now at a higher risk, they're also having to see lower risk clients that probably needed to be seen within the school. And so, I guess, with no coordination of how one cut to one service sector impacts another service sector, cause now their time is spread so thin."

- Mental Health and Addictions

"Well, ideally, we would have a counsellor for each school. And it's a lot of staff and it's a lot of training and it would be really hard to do, but in an ideal world that's what we would get, because then she'd be here same hours as a teacher, or they'd be here same as the teachers are, like 8:00a.m. to 3:30p.m. So, anytime you needed them, unless they were busy, you just go and be like 'Do you have a second? Can I talk to you?', talk it out, get out and get back with your day – and it's just, it's quick. It's easy and you don't have to wait, you don't have to set something up and it's always there for little things and bigger problems."

- Youth

"I think we should have two full-time counsellors in our school – every day – so that our kids have that outlet, that they have that safe place. [Another participant: They should be having the one-to-one support, if necessary, and also someone being able to do classroom intervention, groups, things like that. We would make use of it for sure.]"

- Education Focus Group



4.2.1.5 COMMUNITY RESOURCES & INITIATIVES

Mental health and addictions counsellors described having difficulty discharging youth from their caseloads because, while there may no longer be a need for clinical treatment, these youth would still benefit from some type of support. Unfortunately, there is often “nothing else they can go to”. Stakeholders in child protection and justice described similar frustrations over being unable to continue supporting youth once their mandated reason for involvement is resolved.

Some of the key community resources noted by participants as having the ability to positively support young people included:

- mentorship programs;
- peer support groups; and,
- community centres.

These initiatives have proven beneficial in concert with both prevention and aftercare.⁵⁰ Mentorship programs offer positive role models to help youth work through challenges before they become more severe. These programs also support young people in the “real world” application of strategies and coping mechanisms learned through inpatient or outpatient therapies.

Peer support groups were described as important for youth to hear from other young people who have experienced similar challenges with mental health, addictions, and social issues. Youth said these discussions help to know other young people have similar experiences and offer an opportunity for them to learn how other youth are managing – or have overcome – their challenges.

While several non-profit or community-based organizations do operate these programs and, in some instances, are supported by government funding or grants, these programs are not accessible to all young people. Program options and availability hinges on regions or waitlists, and there can be restrictive eligibility requirements, such as involvement with child protection. Participants indicated that more of these resources are needed to create continuums of care for young people in their communities that would go beyond the need for acute intervention services.

MHAAP System Goal: Create Person and Family-Centred and Coordinated Services

10.3 Incorporate peer supports into service design. Evidence shows peer supports can be effective in decreasing emergency department use and can mitigate worsening of symptoms related to many conditions. Advocates recommend development of formal training and certification of peer support workers.

“Even aftercare, who does that? Very seldom do you hear people that worked or counselled people that they go back and check on that person to see how they’re doing. Very seldom.”

- Elder Advisory Council

⁵⁰ Cyr, C. et al. (2016). Making the Case for Peer Support: Report to the Peer Support Project Committee of the Mental Health Commission of Canada. Ottawa, ON: Mental Health Commission of Canada. (Retrieved from: <http://www.mentalhealthcommission.ca>)

“Mentorship has a really big role. It had a really big role for me ‘cause I couldn’t talk to my mom about what I was feeling. Instead, I talked to my big sister through Big Brothers and Big Sisters about what I was feeling.”

- Youth

Youth participants stated these mentors and peer supports should be available in schools. Other stakeholders suggested these programs be connected to Child and Youth Services for ease of referral and confidentiality. The latter mirrors a recommendation of the **Mental Health and Addictions Action Plan** to incorporate peer supports into service design.

Participants also identified the need for community centres that can provide activities promoting family connection, positive life skills, parenting skills, healthy relationships and culture such as what is provided by non-profit organizations in some areas.

“I definitely want to see more [...] facilities for kids like so they can go, if they are struggling, they can just go there and just like hang with people and just talk and like, not be afraid of how people are going to judge because it’s like you are telling people how you feel, it’s kind of a safe place for you to express yourself.”

- Youth



4.2.1.6 OTHER IMPACTS TO AVAILABILITY OF SERVICE

Young people often have a very “narrow window” within which they are willing to get help. If the young person is faced with wait times and is unable to receive support in the moment it is being sought, the opportunity can be lost. Additionally, a lack of sufficient mental health and addictions counsellors in communities puts strain on other systems. Educators stated teachers “deal with the aftermath every single day” and child protection workers reported having to “wear many hats”. These circumstances can result in increased staff burnout.

“Well, there is a couple problems with resources. Sometimes – well, they have trouble with the lines. Sometimes when the lines are too big that gives them time to think, [...] – when it’s their turn they’re not there to take that hand to help.”

- Youth

Unfortunately, many things can derail this sense of connection. The issue of connection and “fit” is intricately tied to the availability of mental health and addictions service providers at all levels (family physicians, Elders, counsellors, psychologists, psychiatrists and others).

“It’s hard for most teenagers to explain what they’re feeling inside. That’s why it’s good to talk to a therapist every day so we can build up the courage to say what you need to say. [...] It’s kind of hard to ask, but I just wish like I could have more time with a therapist to talk about...because it takes a while for me to get my feelings out. It’s so hard.”

- Youth

Infrequent appointments, time constraints, not feeling listened to and frequent turnover in service providers can negatively impact the ability to build a relationship of trust. Youth do not want to be rushed into confiding in someone who feels like a stranger, retell their stories over and over, or have a service provider jump into providing strategies before being given enough time to explain themselves. Additionally, many youth told us that the traditional approach of sitting across from a doctor or counsellor in an office does not set the tone for a comfortable environment that is conducive for youth to “open up” to a professional.

Youth struggle connecting to people who do not have the same lived experience as them. Young people conveyed wanting to hear from individuals who had experienced similar struggles with mental health or addiction, rather than someone who had only studied it. They also identified a lack of diversity among practitioners in terms of age, culture, language, and gender identity and expression as a barrier to connection. These factors may even impact whether young people feel safe when accessing treatment. In communities where there is only one available service provider, if a youth does not feel comfortable or connect with that person and/or cannot pay for a private service, they are left with no other options.

⁵¹ World Health Organization. (2015). Health for the world’s adolescents: a second chance in the second decade – Section 2: A period needing special attention. Multi-media application. Geneva, CH: Author. (Retrieved from: <https://apps.who.int/adolescent/second-decade/section2/page1/recognizing-adolescence.html>)

“[Connection is] the main thing. You need that first before you’re going to get anywhere with a kid. Trust is really huge. It is because there’s not much of it left.”

- Youth

To develop a trusting relationship and foster a sense of connection, youth described needing to:

- see service providers more often;
- be given adequate time to “let it out” and have their provider “just listen”;
- engage in an activity during a session (especially with younger children);
- meet in a more comfortable/familiar setting, such as their home, a coffee shop or driving around in a car;
- have a consistent provider;
- speak to the same person when calling a help line;
- have adequate planning for transitions between providers, by having more than one provider available and familiar to youth so that when one is absent, another is ready to assist that the youth will already know;
- have a way to contact their former service provider for a limited period while adjusting to the transition; and,
- have broader diversity among service providers.

A young person’s trust is difficult to earn, and in many cases, even harder for the young person to give. For services to be meaningful and effective, relationships must be built, trust must be developed, and connections must be protected.

The Story of Waylon

A heavy burden was placed on school staff when Waylon’s self-harm injuries were serious enough to warrant medical treatment and required a transport to the local hospital. With youth like Waylon with complex mental health needs, the demands placed on school staff exceeded their responsibility as educators.

“I find it really hard to open up to people because people have always left. And so like, [my counsellor] slowly weaned her way into my life I guess kind of. She just took it really slow, and she was really patient and that helped.”

- Youth

“Usually when you talk to older people, they just tell you, like, you haven’t seen life yet. Your only [...] you’re still young. [Interviewer: how does that make you feel?] Like shit.”

- Youth

“There’s two [counsellors in school]. There’s a male and female. I don’t see the male though, because [...] things [...].”

- Youth

"I feel like it's good to have options because lots of people are comfortable with different things."

- Youth

"[W]hen I come to [northern] communities, one of the difficulties [is] you don't know if you're coming back. So, when you're having conversations with the people that you're serving, it's really hard to make commitments for a long time because it is the crisis funding, so you're [...] only approved for the particular month. So, when you're working with youth, that's a really dangerous game to be playing because you got to make meaningful connections."

- Mental Health Counsellor

4.2.2 Out of Reach - Lack of Accessibility

Although a service may exist (i.e., be available) in the province, it is not useful to young people if it is not accessible to them. Our province is expansive and our people diverse. Systems must ensure that the children and youth who need health services are able to physically reach and use them in a meaningful and effective way. Service accessibility can depend on many factors and barriers to accessing services are well cited in the literature.⁵² Participants identified several barriers to accessing existing mental health and addictions services in the areas of:

- Awareness & Finding the "Right" Services
- Intake Processes
- Consent
- Referrals to Specialists
- Transportation
- Hours of Operation
- Language Barriers
- Outreach

4.2.2.1 AWARENESS & FINDING THE "RIGHT" SERVICES

"I think there's lots of probably good programs out there, but nobody knows about them."

- Mental Health Official

As societal attitudes towards mental health and addictions shift and the landscape of services becomes more transparent, people are becoming more aware of resources available to children and youth. Significant efforts have been made by the public health system, communities, and schools. Yet, numerous participants across stakeholder groups continued to speak of a general lack of overall awareness of available services, indicating much more can be done.

⁵² Anderson, J., & E. Howarth, M. Vainre, P. Jones, & A. Humphrey. (2017). A scoping literature review of service-level barriers for access and engagement with mental health services for children and young people. Retrieved from: <http://repository.cam.ac.uk>

Many young people and families reported not knowing where to go when needing help for themselves or their children. This was particularly notable in rural communities and in specific reference to addictions services. Youth indicated that most of the expanding conversations in this regard focus on mental health and that the stigma around addictions has been harder to break.

"[K]ids are scared. They are. And they want help. We don't know where to get it."

- Youth

"Even as a mother, if I was reaching out to help my child or if I was needing help myself, I wouldn't know the first place to look."

- Parent/Caregiver

Finding the right services to meet a young person's diverse needs and comfort levels can also be overwhelming to both youth and their families – especially during a crisis. Although resource directories do exist,⁵³ and the **Mental Health and Addictions Action Plan** recommended these be further promoted and continuously updated, most of the young people and families we spoke to were either not aware of them or did not find them user-friendly. Many young people and parents/caregivers told us that being given a list of numbers to call does not provide enough information or support to make an informed choice as to which service or provider would be the best fit.

"With all of those numbers, I think not having enough information – so you don't know which one to choose."

- Youth

"Some people like talking in an office. I personally don't. I feel very claustrophobic in that environment. [...] Some people like groups."

- Youth

"We're told about the Kids Help Phone, and we're provided with all of these numbers, but we don't really see a face that represents those people that want to help us – just like phone numbers. That's why we easily disregard that they're there – because it's nothing more than a number, it's never fully presented as a person."

- Youth

The **2014 Mental Health and Addictions Action Plan** recommended an "any door is the right door" approach through educating front-line service providers across sectors to better connect clients to appropriate services. Yet, health staff, other community service providers and staff in various child-serving systems indicated not always being aware of all available options, or where to direct youth that approach them for help. While resources such as Healthline 811 can assist individuals in navigating available services, these services do not provide an ongoing case management function.

"I think there's a lot of non-profit organizations that are doing pieces of work, but we just don't know who they are and what they're doing, right? And so, there's a bit of gap in terms of what's happening in communities."

- Mental Health and Addictions

⁵³ Resources include:

1. Government of Saskatchewan Directory of Mental Health and Addictions Services (<https://www.saskatchewan.ca/residents/health/accessing-health-care-services/mental-health-and-addictions-support-services> & <https://www.saskatchewan.ca/residents/health/accessing-health-care-services/health-care-facilities>)
2. Healthline 811
3. 211 Saskatchewan (<https://sk.211.ca/>)
4. Kids Help Phone's "Resources Around Me" (<https://kidshelpphone.ca/resources-around-me>)

**MHAAP System Goal:
Enhance Access and Capacity
and Support Recovery in the
Community**

1. Make services easy to find: create and consistently update a comprehensive, reliable directory of services, including self-management tools for home use.
- 1.1. Promote greater use of HealthLine and healthlineonline.ca for mental health and addictions issues.
- 1.2. Consolidate efforts to develop a mental health and addictions platform that offers access to information and self-management tools, and that links people to services.

"Sure, you can give the child a counsellor's number and let them go home, but they need someone in their life who's going to help them pick up the phone and call that number. Because even just being through foster care, you lack confidence in every stage of it right? So, what 15-year-old is going to start feeling depressed and be like, 'Oh I'm going to pick up the phone and call counsellor.' Like, you know, that's not the first thought going through their mind, right? They start thinking about their learned behaviours, so instead of calling a counsellor, [they're] like, 'Hey, I think I'll just have a drink,' or 'I think I'll just take off and be up to no good or..."

- Youth

"If you look at the youth that we work with, they are marginalized, so they already [...] they might not have a strong parent at home who can advocate for them. They are not able to navigate things as much as another youth. So, user-friendliness of our services is not great, so if there are ways to improve [...]"

- Mental Health and Addictions

The Advocate recognizes that efforts are being made and is encouraged that, in 2021, the provincial government committed additional budget allocations towards mental health and addictions awareness campaigns. To this end, participants stated that more awareness of available services and how to access the right service could be achieved by:

- delivering information to youth where youth dwell, such as youth centres, stores, schools, and social media;
- posting information in bathroom stalls or other locations where youth can access it confidentially;
- holding conferences in rural and remote communities where mental health and addictions promotion has been less active;
- presenting information in a format accessible to everyone from young children to Elders – potentially app-based with identifiable icons for different services;
- humanizing directory information by providing more than "just a number to call", including what to expect when calling or attending a service, who will be helping the youth and details on how it can help them (see text box on Pihtikwe: Beyond the Doorstep for a promising initiative);
- providing northern communities with written information in Indigenous languages;
- providing young people with this information frequently and repetitively; and,
- creating a mental health and addictions coordinator/client navigator role to help youth and their families connect with services and guide them through the system.

**Pihtikwe: Beyond the
Doorstep**

This is a youth-led project facilitated by Community Building Youth Futures of Prince Albert that is working to create an online directory of youth services in that city inclusive of videos depicting exactly how to access the service and interviews with staff. <https://cbyfpa.ca/pihtikwe-directory/>

4.2.2.2 INTAKE PROCESSES

"If us, as professionals, are frustrated with that whole process, I can't imagine what our clients feel with that process."

- Corrections

Participants described barriers created by intake processes that, for the most part, require individuals to contact Child and Youth Services by telephone. While there were some pockets in the province that offered services on a "walk-in" basis, it was reported there is little flexibility in this process. This requirement is particularly prohibitive for individuals without consistent access to a telephone. Stakeholders reported not being able to reach the intake worker when calling, significant delays in having messages returned and – in some cases – their calls not being returned at all. In these instances, youth may lose their courage or motivation to pursue services.

"I can understand that they've [counsellors] had their time wasted by trying to contact people. But if you've got somebody who is struggling already and now, you're expecting them to take the initiative to phone, I find it frustrating. A lot of my people that I see [...], they don't have a phone with long distance or don't have a phone at all. So, I can get them to phone from my office, but they don't always want to do that either. [...] Even for an adult, that's difficult and then you expect a kid or a kid's parent who does not parent very well to be responsible for that. It's sad."

- Physician

Stakeholders called for more options for providing intake information to be made available. Youth asked for the ability to connect with intake via email, social media, or text. However, several mental health and addictions service providers also stated that not having access to cell phones or tablets to communicate back and forth with youth compromised service. Other suggestions included referring agents having the ability to assist their clients in completing intake forms, providing access to an online intake form, offering walk-in/in-person intakes, having ministries jointly fund intake workers in schools, group homes and correctional centres, or having intake workers do onsite intake sessions in rural and remote communities.

4.2.2.3 CONSENT

"If you're too afraid to tell your parents, then I feel like that's the biggest barrier between you and getting help."

- Youth

Many youth who want to receive mental health or addictions services are blocked from doing so if their parents, guardians, or caregivers will not consent to assessment or treatment. Similarly, some Indigenous youth reported being unable to attend sweat lodge ceremonies or other cultural healing practices due to their parents' differing cultural or religious beliefs. In some cases, youth attributed this resistance to a lack of understanding of mental health and addictions issues, in general.

"Most of the time, parents don't even get what you're going through."

- Youth

The Story of Waylon

The last time Waylon was discharged from a mental health inpatient unit and secure detox, he moved to another community. Services were not integrated in such a way to ensure a smooth intake process occurred when he needed to access mental health and addictions services from Child and Youth Services.

"Growing up with my experience, my mom was very ignorant when it came to mental health. She's been my foster mom since I was six weeks old. But when I first started telling her about how I was feeling and how I would self-harm, she would kind of blow it off as 'It's a phase. This is going to just go away once you grow up.' And, of course, it didn't."

- Youth

"I think it's hardest for a parent to acknowledge and act on something's wrong".

- Parent/Caregiver

Many youth participants reported being fearful to tell their parents about needing help with their mental health or addictions and wanted to be able to receive services without their parents' consent.

Children and youth who can form their own views have the right to express those views and have their perspectives taken seriously in all matters that affect them (UNCRC Article 12). This right includes the ability to participate in decisions around their own health. Unfortunately, this right is poorly understood and inconsistently applied across the province.

United Nations Committee on the Rights of the Child

Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment."

(Committee on the Rights of the Child, General Comment No. 4, 2003, CRC/GC/2003/4, para. 11)

In Saskatchewan, there is no legislation defining the age at which a person can consent to medical treatment, including treatment for mental health or addictions issues. Therefore, the province must follow the **"doctrine of the mature minor"** granting individuals under the age of majority (on a case-by-case basis) the ability to make treatment decisions, provided the young person can demonstrate the capacity to fully appreciate the nature and consequences of the medical treatment and their treatment provider believes the treatment is in their best interest.^{54 55} Unfortunately, the gap left by this lack of legislation has caused confusion in practitioners and policy makers across the province. Some providers offer services to a young person upon their request, however, others require consent from one or both parents for a child or youth to access service. This can be particularly problematic in cases involving contentious parenting/custody disputes.

If a young person believes they require mental health or addictions services, it would be very hard to find the reason why this may not be in their best interest. Policymakers and service providers must become better informed of young people's rights to ensure that their ability to consent to their own treatment is consistently applied across the province.

4.2.2.4 REFERRALS TO SPECIALISTS

Participants reported there are "so many hoops to jump through" to be referred to a specialist, such as a child psychiatrist or child psychologist.

Foremost among these was the need for referrals to be made by a family doctor or pediatrician. This requirement is a barrier to many young people who do not have a family doctor, face an additional wait to see a pediatrician, or do not have access to a pediatrician in their community.

54 AC v Manitoba (Director of Child and Family Services), 2009 SCC 30, [2009] 2 SCR 181. (Retrieved from: <https://www.canlii.org/en/ca/scc/doc/2009/2009scc30/2009scc30.html>)
55 Coughlin, Kevin W. (2018). "Position Statement: Medical decision-making in paediatrics: Infancy to adolescence." Paediatrics & Child Health, 2018, Volume 23, Issue 2, pp. 138-146

"They either need a car or [...] generally need to talk to their parents and not everyone wants to do that."

- Youth

Additionally, when a young person seeks treatment from their family doctor, a specialist referral is often made only after other methods have been attempted and failed. Mental health counsellors explained that children are often referred to them when there is a clear need for a psychiatrist. The counsellor must then send the child back to their family doctor to get the appropriate referral. It can be very challenging for parents/caregivers to get young people to these numerous appointments.

4.2.2.5 TRANSPORTATION

"They don't have the ability to hop in their car and drive over to wherever the services are."

- Health

The concepts of accessibility and availability are intricately tied together. One of the ways in which this is most apparent relates to difficulties with transportation to and from services, especially when services are located far from one's community. This issue disproportionately affects young people, and often, youth and their families depend on others for transportation.

Some of the most common barriers faced by youth, as identified by stakeholders, include:

- family members that are unsupportive of treatment and unwilling to transport;
- family members that are unable to take time off work or leave other dependent family members for extended periods of time;
- conditions of poverty, including the lack of a reliable vehicle and/or money to pay for gas, overnight accommodation, and meals;
- inconsistency in the operation and availability of medical taxis or similar transportation services offered in some rural and First Nations communities;
- reliance on ambulances to transport youth from remote northern communities to urban centres leaving communities vulnerable and, often, the youth with no way home;
- the need for youth to miss significant amounts of school to attend regular services in far away communities; and,
- lack of money for a bus or cab, or complicated public transportation systems that can be intimidating for youth, especially those without a smartphone or Wi-fi connection to assist with navigation.

The Story of Jess

"The problem was driving to the counsellor [...] It's not the problem of driving, it's the time that they are away from their class. Because she has to basically miss a half a day of school every time. [...] And if they aren't ones that are gonna dig in and catch up, they get behind."

- Caregiver

Youth participants offered several suggestions for breaking down transportation-related barriers in urban communities, including:

- shuttle services, such as those provided by hotels and mechanic shops;
- student mentors or liaison workers in schools that can transport youth to appointments;
- counsellors that pick youth up and take them for a drive during their appointment time; and,
- situating service centres within walking distance of schools so youth can easily get themselves to appointments.

4.2.2.6 HOURS OF OPERATION

"Just to have someone there. Like, all the time. Like any time of the day."

- Youth

The standard business hours kept by most mental health and addictions outpatient services were identified as a barrier to access. It is a hardship for youth to attend appointments during the day, either due to missing school or their parents/ caregivers being unable to take time off work to attend with them. These barriers are compounded when youth must travel long distances for these appointments.

Youth indicated often feeling better during the day when distracted by school, work and other positive social interactions. Many reported mental distress or substance use triggers typically occur at night or on the weekends. In these instances, youth would greatly benefit from being able to speak with a mental health or addictions counsellor that is familiar with their circumstances, rather than having to use a help line and repeat their story to various strangers over again and again.

"Usually, a counsellor will work 9:00 a.m. to 5:00 p.m., but what happens if, at 6:00 p.m., you're having a crisis situation? So, yeah, time of day is very important with a barrier. And there is Kids Help Phone and stuff, but it's not face-to-face, which is so much better than just over the phone. [...] I think seeing eye-to-eye, like physically, is a lot better and you can see their facial expressions and they can see yours. I've always liked face-to-face more than phone calls or text messages."

- Youth

Parents/caregivers and group home operators stated that "unless it is a life-or-death situation", their efforts to manage a youth's crisis until the next day are very difficult. Mental health and addictions professionals also expressed frustration with this situation, stating:

"Our hours of service are 8:00 a.m. to 5:00 p.m. Monday to Friday. And so, I think if a young person needs services, [...] often it's going to the hospital emergency department or calling 811. [...] They're not really designed for youth or children. They are primarily designed for adults."

- Mental Health and Addictions

The Story of Jess

"It was hard to get out there, especially 'cause all of the appointments were during school hours, so that's when I take my on-line classes that I'd have to do again. [...] So, that was my big thing was trying to get there and be there on time [...] 'cause it is a good hour and something [away]."

Police and Crisis Team (PACT):

PACT pairs police officers with mental health workers when attending to calls related to people experiencing mental health and/or addiction-related crises. PACT has recently been expanded to operate in 6 communities (Saskatoon, Regina, North Battleford, Moose Jaw, Yorkton, and Prince Albert). The PACT units provide real-time crisis response, avoid escalation, and help direct individuals to appropriate services, thereby preventing unnecessary visits to the emergency room or entries into the criminal justice system.

(<https://saskatoonpolice.ca/pact/>)

"People are not objects. People can't just be put on the back of the desk and wait 'til Monday. So, I think that the people that organize these services have to remember that. This isn't an administrative office where you roll a piece of paper onto the back of a desk – these are people who could be dead tomorrow by suicide if something isn't done. It's not the same work."

- Mental Health and Addictions Official

Crisis workers, such as Police and Crisis Teams (PACT) and those employed by Tribal Councils, were also identified as helpful in managing urgent events beyond the typical 9-5 timeframe. However, these resources are not widely available across the province and do not provide the level of consistent, ongoing support youth are looking for. Some communities have centres with dedicated drop-in times operating outside of regular business hours, that do not require an appointment to be made in advance. Youth felt this model would be helpful, if there is some familiarity with the individuals providing drop-in service.

"It's always been brought forward to have more of a 24-hour counselling service or having us work at a time where it was more appropriate for people who work or children and youth who maybe come at midnight"

- Mental Health and Addictions

"There's a lot of ways where the traditional mental health and addiction supports don't work, whereas they're, like, 'Okay, the client has to come to my office.' I mean, for a lot of our youth, that's just not possible for them to be expected to do that."

- Corrections Official





**"Words are too high.
[...] You can say
something simply
and come to the
same point."**

- Elder Advisory Council

**"For me, it's just
more beneficial
to have someone
actually sitting
there listening
to you in the
same room."**

- Youth

4.2.2.7 LANGUAGE BARRIERS

Language barriers can arise for children and youth whose first language is not English, such as northern Indigenous and newcomer youth. It is very difficult for counsellors to provide meaningful service when language barriers exist and there are not enough resources to address them.

Our Elder Advisory Council emphasized that even the use of the term "mental health" does not connect with some Indigenous peoples who do not have a parallel phrase in their language. If the ways in which people talk about well-being are not honoured, respected, or recognized within service provision, they may not feel comfortable accessing the service.

"When you translate mental health in Dene, it's pretty hard to do. [...] There's many ways you can translate it, [...] but really, when you translate it in Dene, it sounds like "crazy people". [...] So, the promotion I think we need to do a bit more work on."

-Health (northern Saskatchewan)

In addition to a wider diversity of clinicians, participants identified the need for more interpreters who speak the language of newcomer families. Stakeholders in education stated that there has been an increase in students enrolled in English as an Additional Language (EAL) programs that have experienced trauma and have undiagnosed mental health disorders. If an interpreter cannot be accessed, appointments and assessments may not take place until a child/youth has learned English.

Education staff highlighted the need to conduct assessments using an interpreter as early as possible, rather than delay the process. The need for service providers to better understand the cultural background of newcomer families and to properly communicate with newcomers about the services offered to provide information and address concerns was also cited as necessary.

Language can also be a barrier when providers do not communicate with patients and families in clear, understandable terms. It is important that child and youth-friendly language is used, that enough information is provided about what a diagnosis means, what youth can expect as a result, and what strategies can be used to take care of themselves. When these things are not sufficiently explained in appropriate language, young people can be left feeling lost and unsure of what to do next.



"My granddaughter called me up one day and, 'They said I'm bi-polar. What does that mean?' She claimed they didn't even explain it to her [...] and never really gave her follow-up supports either."

- Elder Advisory Council

4.2.2.8 OUTREACH

The typical approach to provincial community mental health counselling is built around in-office visits at Child and Youth Services. This approach is meant to meet the high demand for service by allowing each counsellor to see more clients in a day. However, clinicians report this comes at the expense of providing more effective service in locations where youth can access the service and feel more comfortable.

In contrast, community addictions counsellors are more likely to provide services in schools, custody facilities and other places where youth spend most of their time, which stakeholders reported works well. Although similar outreach is conducted by mental health counsellors in some communities, these services are not widely available and wait lists were reported as being high. Participants across stakeholder groups agreed that mental health services should also follow an outreach approach, but acknowledged that this would require additional investment and resources.

Related to the discussion on the lack of school counsellors, stakeholders called for outreach services to be provided in schools as this is where young people spend most of their time and, therefore, addresses several barriers at once. However, youth who experience mental health challenges often also lack stability in their lives, can be transient and may not attend school regularly. Therefore, stakeholders indicated there was also a need for mental health counsellors to regularly attend group homes, youth shelters, youth jails, recreational centres, youth centres and so on.

Outreach can also be done virtually. The COVID-19 pandemic has shown that more services than previously considered can be provided in this way. The health system has long been offering virtual services in some communities via Telehealth. If available, this service can reduce the need for travel and avoid disruptions for families. Many young people are adept at communicating by video and welcomed the idea of virtual counselling.

Other young people described texting as easier and less anxiety-inducing than talking to someone (either virtually or in-person). For these youth, the text and chat functions of Kids Help Phone were identified as an approach that is working well and that should be incorporated into ongoing counselling services. However, many other children and youth either do not have devices permitting this type of connection or prefer to meet with a mental health professional in person. This desire flows from a need for connection, trust, and relationship-building that youth stated is best done face-to-face. These differing perspectives indicate that a variety of outreach options are needed.

One promising suggestion to address the impersonal nature of virtual services was for clinicians to first visit rural and remote communities in-person and get to know the youth requiring service before then providing ongoing service through a virtual format. Youth also suggested having a computer or other technology and a safe space available at school to connect virtually with service providers.

**"I think, if you
have a school
that is a positive
environment
for them, [...] then why are
we making
them leave
that place to
go talk to
somebody else
in a place that
clearly the
parents don't
want them to
be, and the
kids don't
want to be?
That's the
conversations
I've had with
kids."**

- Education

FRIENDS Program

One creative way to get mental health services to young people who need it was the “Friends Program” currently being delivered in some Saskatchewan schools. This program delivers cognitive behavioural therapy in health class to students in grades 1, 4, 6, and 9. While health offers training and budget support, the program is delivered by trained teachers. Its strength is that it is provided universally to children and youth in those classes and young people do not need to identify as needing care. This approach breaks down barriers for youth whose anxiety or other concerns may prevent them from seeking individual services.

(<https://friendsresilience.org/>)

Telehealth Saskatchewan

Telehealth Saskatchewan links patients with health care providers, including mental health professionals, across the province using secure videoconferencing technology. At the date of publication, Telehealth was operating in 134 communities across Saskatchewan. (See: <https://www.ehealthsask.ca/residents/Pages/Telehealth.aspx>)

4.3 Access to Culturally Appropriate Services for Indigenous Youth

“Even if [the Elder] just talked to a student, it could improve their mental health for days.”

- Education

Indigenous children, youth, and families in Canada continue to experience the devastating consequences of colonialism and residential schools that resulted in the catastrophic loss of culture, language, spirituality, family, and community connections. In many cases, these essential building blocks of development have been replaced with trauma, loss of identity and higher rates of suicide and deaths related to alcohol or drug toxicity among Indigenous youth as compared to their non-Indigenous peers.^{56 57} Considering that nearly one in four youth in Saskatchewan is Indigenous,⁵⁸ it is imperative that mental health and addictions services are effective in meeting the needs of Indigenous young people.

To fulfill the right of all children to the highest attainable standard of health, governments must actively identify disadvantaged children and take “special measures” to allow them to realize their rights at the same level as other young people.⁵⁹ There is no doubt that Indigenous children and youth should be subject to these special measures to address current inequities. This responsibility was further affirmed when Canada codified its commitment to implement the United Nations Declaration on the Rights of Indigenous Peoples,^{60 61} and pay “particular

“You need to know who you are and where you came from. [...] This is a bigger issue, and it needs a lot of work. [...] The biggest thing is identity for the youth – for our children.”

- Elder Advisory Council

attention to the rights and special needs of indigenous [...] youth and children and persons with disabilities”. By extension, these rights obligate our public health system to ensure “that additional financial and human resources are allocated to mental health care for indigenous children in a culturally appropriate manner, following consultation with the affected community.”⁶²

The Calls to Action of the Truth and Reconciliation Commission (TRC) and the recommendations of the 2014 Mental Health and Addictions Action Plan have provided further direction in this area – largely centred around the need for more Indigenous mental health and addictions practitioners, as well as the need for services and facilities developed by, or in coordination with, Indigenous peoples.

Young people, in general, relate on a different level to people who understand them and their experiences. Indigenous youth have unique but collective experiences in relation to the impacts of colonization, discrimination, and intergenerational trauma. Due to these factors, Indigenous young people indicated feeling more comfortable sharing their

struggles with other Indigenous people. However, it is difficult to access an Indigenous mental health or addictions counsellor. Additionally, stakeholders in the North indicated the potential for brief and inaccurate assessments can be particularly problematic for Indigenous youth who have difficulty relating to non-Indigenous health care professionals.

“I don’t see a lot of Indigenous counsellors. Like [...] it’s all white people.”

- Youth

“Being First Nations, because counsellors [...] like [...] a lot of Native people have addictions and mental health issues, so when you go into see a counsellor they are like, ‘Oh it’s a Native person, I know how to help them’ – without actually even listening. They just assume that they know how to do things.”

- Youth

“When I was younger, I been through so much. Like, I’ve been through abuse and all. I used to have counsellors just because of that when I was in elementary. The counsellor, she seemed a bit judgmental because I was in a white school. And there was no help with her. She didn’t really help me at all. I was at my lowest and she didn’t really seem to understand or help.”

- Youth

56 Saskatchewan Coroners Service. Drug and Alcohol Toxicity Deaths for Ages 0-17, 2016 to 2021 (Gibson, S. Email to M Macomber. 19 November 2021)

57 Information provided to the SACY by the (formerly named) Office of the Chief Coroner of Saskatchewan (30 August 2017).

58 Anderson, T. (2021). Chapter 4 – Indigenous Youth in Canada. A Portrait of Youth in Canada: Data Report, Statistics Canada Catalogue no. 42-28-0001 (Retrieved from: <https://www150.statcan.gc.ca/n1/en/pub/42-28-0001/2021001/Article/00004-eng.pdf?st=s-m0lW6U>)

59 Committee on the Rights of the Child. (2003). General Comment No. 5 (2003) General measures of implementation of the Convention on the Rights of the Child. Geneva, CH: Author. CRC/GC/2003/5 (Retrieved from: <https://www.refworld.org/docid/4538834f11.html>)

60 United Nations General Assembly. (2007). United Nations Declaration on the Rights of Indigenous Peoples. A/RES/61/295. (Retrieved from: https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf)

61 Government of Canada. United Nations Declaration on the Rights of Indigenous Peoples Act, SC 2021, c 14 (Retrieved from: <https://canlii.ca/t/b9ql>)

62 Committee on the Rights of the Child. (2009). General Comment No. 11 (2009) indigenous children and their rights under the Convention. Geneva, CH: Author. para. 55CRC/C/GC/11 (Retrieved from: <https://www.refworld.org/docid/49f6bd922.html>)

TRC Calls to Action 18 – 24, in part, included the need for:

- Sustainable funding for Aboriginal healing centres;
- Recognition of the value of Aboriginal healing practices and to use them in the treatment of Aboriginal patients;
- Increase the number, and retention, of Aboriginal health care providers; and,
- Provide cultural competency training for all health care professionals.

MHAAP System Goal: Partner with First Nations and Métis Peoples

13. Partner with First Nations and Métis peoples in planning and delivering mental health and addictions services that meet community needs:

13.1. Design services in partnership with First Nations and Métis organizations, communities, and Elders;

13.2. Ensure ongoing dialogue and coordination between regional health authorities (RHAs) and First Nations and Métis organizations and communities; and,

13.3. Improve the cultural responsiveness of services respecting the history of First Nation and Métis peoples.

“[T]hings like talking to an Elder or cultural activity are very important. I think identity is a major part of who you are and when you’re a youth, you’re still developing your identity and things like that do help.”

- Youth

Numerous participants, including young people, identified the need to utilize more Indigenous Elders and to employ more Indigenous counsellors within the current mental health and addictions system. However, the Advocate acknowledges this may be a challenge given the high demand for Elders to support Indigenous young people in all public systems including social services, education, and justice.

The lack of Indigenous presence in the health system overall has been noted as a shortcoming, but health officials indicated there are challenges in recruiting and retaining Indigenous people in available positions. It may be that more effort is required to ensure Indigenous people feel valued and safe within educational programs and workplaces to attract more Indigenous service providers to these roles.

“[I]n my area, I have six First Nations communities. [...] We don’t have First Nations counsellors and addictions counsellors applying for our jobs or staying in our jobs. So, we are missing a cultural component in our staff to address some of those traditional, kind of, cultural aspects to health.”

- Mental Health and Addictions Official

There is also a need for greater availability of wellness and healing approaches grounded in Indigenous ways of knowing. Young people indicated the need to access Indigenous cultural practices and spiritual ceremonies to promote resilience and healing. However, access may depend on geographical location and mobility, funding, and whether their family/caregivers practice or expose them to elements of Indigenous culture.

“[W]hen I was in grade 9 and 10, I went on a sweat [...] that really helped with what I was going through. And me being Indigenous myself and being related to people who live on the reserve, I do have access to things like that – but not everyone does.”

- Youth

“Most of our patients are Aboriginal. So, they tend or are inclined to their cultural way of seeking help. But how much of that is available?”

- Psychiatrist

“Our people need help. It’s not their choice they end up here and where they are.”

- Elder Advisory Council

There are areas of the province where access to Indigenous cultural services is improving. Many First Nations Bands and Tribal Councils offer cultural wellness, healing, and support services. Within Saskatchewan’s provincial health system, recognition of the need for and inclusion of Indigenous cultural components is growing. The health system’s involvement in the All Nations Healing Hospital in Fort Qu’appelle, as well as Native Health Services and the Randall Kinship Centre in Regina were identified by stakeholders as models that work well to meet the needs of Indigenous families.

"Because they know where [we] come from and all. They're more understanding. [...] They just get it."

- Youth

"I just accessed the Elder [at the Randall Kinship Centre] service for the first time, basically, and it blew me away. [...] In one appointment, the Elder was able to do more with a family than I could over multiple appointments – because they got it. They could come from a context that I just can't – or if I can, I'm just wading through what I've learned. I am not steeped in that context, right?"

- Mental Health Counsellor

Additionally, cultural support is provided to a limited extent within the larger inpatient mental health units, addictions treatment centres, custody facilities and schools. The impact of these services is very positive, however, stakeholder groups stated more is needed.

"When I was in the psych ward, when culture was offered to me there, that was lots and lots of help. [...] Talking to Elders, sweats, ceremonies, being introduced to it. [...] I think it was being able to talk to somebody, like, just an Elder in general – somebody, like, First Nations. It made me feel more comfortable talking and being open about things and getting help."

- Youth

Randall Kinship Centre (RKC)

RKC is a voluntary program located in Regina designed to meet the needs of families with children facing disruptive behavioural and mental health challenges. It provides outreach services in a holistic and culturally affirming way.

(<https://www.rqhealth.ca/facilities/randall-kinship-centre>)

"I was just thinking from a frontline perspective about First Nations cultural support. We have had some here, in our [addictions] facility [...], and we have had really great support. Just seeing the impact of that [...] but, I know just from other areas too, it just seems like it's a small amount. It needs to be more. [...] Just the access to information, the access to cultural practices, interaction with Elders. We see a lot of youth who have no connection to their culture, and it's their first taste of learning. [...] And even the non-First Nations youth, too. There is a lot of teaching about the experience of the First Nations people, but there is also a lot of just understanding the perspective of other youth."

- Addictions Centre Staff

The Advocate's Elder Advisory Council validated the concerns raised by youth over the lack of opportunities to access the preventative and healing aspects of Indigenous culture and ceremony in their communities. The Elders have seen many young people who discover their Indigenous culture – and the benefits it has on their well-being – thanks to the programming provided in custody facilities or other institutions, who then lose access to these opportunities once released. Considering the positive impacts it has on all aspects of life, the Elders stated all government departments have an obligation to make Indigenous cultural and spiritual opportunities, such as sweat lodges and culture camps, more available and accessible to youth throughout the province.

"We need to do this. We need to do it for us. We need to participate in something that makes sense to us. You know, what the psychiatrist is saying does not make sense to me, but what this Elder says, makes a whole lot of sense."

- Elder Advisory Council

"Inclusion and diversity. [...] Our people want to see our people at the higher levels."

- Elder Advisory Council

UNDRIP Article 23

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Participants stated that Indigenous cultural healing practices have historically been an afterthought in all systems – not just healthcare. Some conveyed this was due to not having Indigenous people in decision-making roles, and a corresponding lack of understanding and respect for the healing influences of Indigenous culture.

"[O]ne thing that I feel has been, really, a challenge that I don't feel gets addressed [...] is that when somebody says, 'Oh, we want so and so to see a psychiatrist, [...] a psychologist', automatically, in that person's mind they have a perception of what the qualifications of that person is, what type of supports they're going to receive, right? Even though they might not even receive that support. But then when we say, 'Oh, we want them to see an Elder', [...] I can see the eyes rolling already. Right? [They're thinking] 'Well, how's that going to help? How does culture help?' Right? And so, I think we do a really poor job, generally - and I say we, as a community – how do you develop the metrics around...how does culture involved in healing get the same type of respect as a psychiatrist or psychologist, that they can kind of complement each other?"

- School Social Worker

We note that officials within the provincial mental health and addictions system expressed awareness of the need to close this gap. There was acknowledgement that, while there are "pockets" of services and models across the province that serve Indigenous youth and families well, these initiatives need to be expanded.

It was also recognized there is a need for culturally appropriate services to be outreach-based, trauma-informed, holistic, and able to work with entire families to ensure everyone's needs are met – and that this process must include building upon relationships with Indigenous partners.

"A relative of mine said, 'My grandson is 16. He doesn't talk to us. He doesn't eat. He doesn't come down to visit us. He doesn't participate. He doesn't do anything. My grandson's going to kill himself. I know that. This is where it's heading. [...] So he took his grandson into the lodge. [...] When he came out after the lodge, he looked different. He actually was talking to us and telling us about his experience. And he actually smiled, and I watched his grandfather cry. [...] Some of the methods we have are very powerful.'"

- Elder Advisory Council

"Like the drum – it's a medicine. [...] The drum is like a way to heal and when you jingle dress it's like praying to heal – you're praying for everyone to heal. [...] And it's one of the medicines I take. [...] [Y]ou never have bad thoughts when you're dancing or drumming."

- Youth

These acknowledgements align with the *Declaration, the Memorandum of Understanding on First Nations Health and Well-Being* signed between the Saskatchewan Ministry of Health, the (now) Federation of Sovereign Indigenous Nations (FSIN) and Health Canada in 2008, as well as FSIN's subsequently developed Culturally Responsive Framework.⁶³ The Culturally Responsive Framework (CRF) is meant to ensure Saskatchewan's health system respects and incorporates the cultures of First Nations patients, families and employees into the delivery of mainstream services, while also restoring and enhancing First Nations' own health systems. The CRF further led to the development of Indigenous Cultural Responsiveness Theory (ICRT) by Indigenous scholars in Saskatchewan. This theoretical framework provides "a decolonized pathway designed to guide research that continuously improves the health, education, governance, and policies of Indigenous Peoples in Saskatchewan."⁶⁴

The successes seen in several Indigenous communities across Canada⁶⁵ that have harnessed the preventative and healing potential of culture and land-based traditional activities should be evidence enough of the need for the provincial healthcare system to accelerate action on expanding culturally appropriate services to meet the needs of the Indigenous children and youth it serves. Any roadblocks to this action must be identified and problem solved. The frameworks through which to do so already exist.

63 FSIN. (nd). Culturally Responsive Framework. (Retrieved from: <https://allnationshope.ca/userdata/files/187/CRF%20-%20Final%20Copy.pdf>)

64 Sasakamoose, J. Bellegarde, T. Sutherland, W. Pete, S. McKay-McNabb, K. (2017). Miyo-pimātsiwin Developing Indigenous Cultural Responsiveness Theory (ICRT): Improving Indigenous Health and Well-Being. *The International Indigenous Policy Journal*, 8(4). (Retrieved from: <http://ir.lib.uwo.ca/iipj/vol8/iss4/1>)

65 For example, see: Snuneymuxw First Nation (<https://www.snuneymuxw.ca/press-coverage/first-nations-facing-suicide-crisis-solution-rooted-community>) & Heiltsuk Nation (<https://www.macleans.ca/news/bella-bella-the-town-that-solved-suicide/>)

4.4 Hospital and Acute-Care Services

The reactive nature of the mental health and addictions system leads many youth and families to seek hospital-based or acute-care services, typically when at the end of their rope or where there are no other available options. Participants reported significant and similar gaps relating to both mental health and addictions hospital and acute care services for young people. Since the impact on the lives of young people differed, mental health and addictions services under this overarching theme will be discussed separately.

4.4.1 Mental Health – Emergency Room and Inpatient Facilities

When youth attend an emergency room in a mental health crisis, either the young person or their caregivers believe that some sort of intensive treatment is required. This is understandable as many caregivers do not know what to do, how to help, or are scared the young person will hurt themselves or worse.

"I think what happens is, it becomes almost where you lack capacity at a critical level – it becomes a redefinition of what is critical."

- Child Welfare

Often, the caregivers and/or youth are hoping to be assessed by a psychiatrist or admitted to hospital. However, these expectations are not typically met. Acknowledging that not every young person experiencing mental distress needs to see a psychiatrist or be admitted to hospital, stakeholders stated that many young people are not receiving the level of service required to meet their needs. Stakeholders conveyed that a decision to grant access to specialists or admit to an inpatient unit is often influenced by a lack of capacity and resources within the system, rather than on the needs of the patient.

"Our acute [care demand] has gone up so much in the emergency departments that it's raising the acuity across all of our services in the community as well. So, as a public service, we're dealing with a more, a sicker population – more people, and thus if there are more people, only the most acute of the acute get in and everybody else is turned away or discharged or not even admitted. [...] So, it really drives up the acuity across our whole continuum of services in that regard. [...] Prevention work has...we have not been able to put our resources there. They've needed to go to the most sick and acute of our mental health and addictions population."

- Mental Health and Addictions Official

4.4.1.1 EMERGENCY ROOM EXPERIENCES

"I don't know if I've had a client that's actually been admitted. They've all been sent home."

- Corrections

A common experience described by participants involved young people facing lengthy waits in emergency rooms to see a doctor or psychiatrist, feeling as if their concerns were dismissed, and ultimately being sent home without proper support.

The Advocate recognizes there are wait times to be seen by any specialist in hospital and that this concern is not unique to mental health professionals, such as psychiatrists. However, the way in which this is experienced by youth and the impacts it has on their well-being must also be acknowledged. In some cases, delays can make matters worse for the youth, place significant strain and expense on other systems when social workers, corrections staff or police officers are required to wait with them or end in youth leaving the hospital before receiving treatment. The Saskatchewan Health Authority has made recent inroads in decreasing emergency wait times generally in Saskatoon and elsewhere.⁶⁶ The reported average provincial wait time for a young person to receive an initial physician assessment for a mental health or addictions-related concern is approximately 80 minutes.⁶⁷ Psychiatry consults are not required in every situation. However, when requested by emergency room physicians, information on the length of time it took to see a psychiatrist was not available.

"Waiting in those hospital rooms for like another doctor or psychiatrist to see you, kind of like does damage to your brain mentally, like for me it is. So, I was like kind of going crazy in there. Pulling my hair out and stuff like that. [...] One time I went there, and it was like 10:00p.m. and then they're like 'Yeah, you can see a psychiatrist in the morning.' So, I'd be there all night and it was just [...] there was nothing to do but go crazy."

- Youth

Stakeholders also reported concerns that once an assessment does occur, it is often based on a moment in time rather than a broader review of the circumstances that led to attendance at the hospital. Families and caregivers reported that in some cases, young people who have waited long hours or had to travel long distances may appear to have calmed down by the time they are assessed, however, once released their risk persists. Parents/caregivers said this is very scary when their youth has attempted suicide or significantly self-harmed.

⁶⁶ Provincial Auditor of Saskatchewan. (2021). Report of the Provincial Auditor to the Legislative Assembly of Saskatchewan: 2021 Report - Volume 1. Regina, SK: Author.

⁶⁷ Email Communication from Ministry of Health to Advocate for Children and Youth, 13 January 2022.

"Everyone I have known that has gone there for help hasn't gotten it. They walked out of there and they felt ten times worse than they did when they walked in. And I am, like...that's pretty sad in my opinion in that we can't even go get the help we could, because we try, and we are not listened to. Or me, personally, I was never admitted. They probably should have admitted me, personally, I think looking back. I wasn't in any state to leave the hospital. I probably should have been there, and they never kept me. They told me I was fine every time."

-Youth

The feeling of defeat experienced from not receiving the service one expected can be exacerbated by interactions with hospital staff who stakeholders described as often being too busy to offer the compassion needed in these circumstances. Numerous stakeholders reported being treated in ways that were felt to be insensitive or dismissive.

While we did not verify these concerns and recognize that individuals under stress may not receive comments in the way these were intended, their experiences and perceptions are important to acknowledge to ensure services are delivered and received in a way that leads to effective and meaningful outcomes.

"I talked to a psychiatrist, and he told me that if I actually wanted to kill myself, I would be dead by now. So, I was like, 'Okay. So now I am being tested.' So, I went home that same day and just tried again. I went back to the hospital the next day and I still... [...] I never once got admitted to the hospital. In the span of eight days, I tried killing myself, I would say, at least four times and they never admitted me. They just told me, 'If you wanted to be dead that bad you would be.' I was like, really? I have been back here four times. Like, I shouldn't have to come back a fifth time in a body bag for you to do something about it."

- Youth

"We had one [instance] where we're like, 'This youth is going to run'. And the youth's like, 'Yeah, I'm going to run - I'm going to go and hurt myself.' And the psychiatrist said, 'Go ahead and run. Go ahead and die.' And she ran. So, stuff like that where it's like, why is that kid ever going to want to go back there?"

- Child Welfare

"So, what doesn't work is how you're treated. And how there was shame. Like [my child] felt like there was no compassion for her. She felt, umm, she felt very judged. Like she was bad for just wanting to end everything."

- Parent/Caregiver

"There's a lot of racism that our First Nations people are experiencing as well in the health field. [...] Especially when it comes to attempted suicides, a lot of the doctors don't seem to be taking it seriously. They'll see the kids and say, 'Oh, they're okay,' and send them home. And then, before you know it, we're having a funeral."

- Child Welfare

The Story of Waylon

Waylon was transported to the local hospital due to injuries on both arms and forearms. Psychiatry was consulted and he was released to the care of his parents after he agreed to the safety plan. Ten days later, he was transported to the local hospital again when he attempted suicide by overdosing on his medication. He was then admitted to the psychiatric inpatient unit.



"Our people are scared to use the hospitals. [...] They'd rather stay home and suffer until they really have to go. [...] They are scared of that disrespect. They live with it every day."

- Elder Advisory Council

"[My child attempted suicide] and I found a suicide note. [...] Like, it's just [...] it's so quick and sometimes the whole picture isn't being seen. [...] I just felt like, I'll be honest, I felt like 'another Indian' in that office. Like, not valued. [...] In the South, especially when you come from the North, you're not necessarily seen as a person. You're just seen as another [...] another statistic."

- Parent/Caregiver

The Advocate acknowledges that health staff are well-intentioned, but are overworked and/or may be experiencing compassion fatigue due to an under-resourced system. Alongside the previously discussed need for more psychiatrists, continued action to ease burdens on emergency room staff, in general, would allow the time necessary to ensure patients feel heard and may be a way to reduce these negative experiences.

"The times that we had someone come down and sit with us, was amazing! Those interns, doctors, I don't know always who they were, but they were thorough. They were patient. It was not rushed. I felt like they were one of the only...they took the emotional side and the psychiatry side and kind of put it together [...]."

- Parent/Caregiver

When a young person's mental health struggle has reached the point that they feel it is an emergency, it is imperative that they feel heard, respected and supported in their time of need.

Additionally, participants – including members of the Advocate's Elder Advisory Council – called for increased and/or improved training for all health staff in culturally appropriate service delivery to Indigenous people. While there are training initiatives in place, the health system may need to consider whether they are having the required impact and outcomes, as well as whether they can be expanded.

Following assessment – either by a physician or psychiatrist – stakeholders conveyed, "the only option is you either get admitted or you get discharged", with nothing in between. Significant concerns were raised over what was described as a lack of sufficient follow-up support and safety planning. Many stakeholders reported leaving emergency rooms with only a number to call to request outpatient counselling, and instructions to return to the emergency room in the next crisis.

"Like, when my sister [...] she was being extremely like suicidal, so we took her to [our community's] mental area and they literally kept her there for two hours because she cut herself. So, they gave her stitches and they kept her there for two hours and they told her to go home. They literally looked at my mom and said, 'She is fine to go home.' But we couldn't. That was the fifth time she was at the hospital for stitches [...]."

- Youth

"It's like multiple times that this young person had to go through the struggles they're going through before they'll actually finally keep them to hopefully do some evaluation with them."

- Group Home Operator

"I tried to kill myself this one time, and all I had to do was promise the doctor I wouldn't do it again and he just sent me out. And it was like the psych ward was busy, or something like that, and I was like – it was both times – and I just promised him I wouldn't do it again and then they just sent me home. There was no safety plan, discharge plan or anything."

- Youth

This response can be especially defeating when outpatient services are not easily accessible in a youth's community and/or if there is a lengthy wait time. Stakeholders reported that youth in these circumstances often end up back at the emergency department within days or weeks.

"We went south to ensure her safety and we didn't get that. I also did not get any recommendations on how to deal with her at home. The only recommendation I received was – 'If she was suicidal, bring her to the ER.'"

- Parent/Caregiver
(Northern Saskatchewan)

"I told [the doctor] to give me some [...] sleeping pills, because I'm taking her home and I guess I gotta frickin' figure this out myself. [...] I got her home, and I gave her a sleeping pill and I slept with her, and we put her bed right by her door so if she tried to open the door I would wake up and left the lights on outside. And we stayed home with her for two days and she wasn't out of our sight. [...] When my sister found a place that [she] thought that maybe would work [outside of Canada] ... and then we were on the plane. [...] I felt I had no help, like I [...] 'What do I do?' [...] I was absolutely spinning [...] 'Okay, so I got to take her home – what do I do?' And I'm angry because – what about these poor parents that have to take their kids home, that have to take their baby home, and they're paycheque to paycheque, and they can't stay home for suicide watch? What do they do?"

- Parent/Caregiver

"They sit there, they see a doctor, the doctor says, 'No, not suicidal. Go home,' and then there's nothing after that – unless the client goes in [to outpatient counselling] themselves and that doesn't often happen."

- Corrections

The health system has worked to address these gaps in some communities by creating Child and Youth Transition Teams that include psychiatric liaison nurses and social workers scheduled in alignment with peak emergency hours. The psychiatric nurse can meet with youth and their caregivers, gather information and either consult with the emergency doctors to treat the young person or recommend a referral to psychiatry. If the youth is not admitted, the social worker facilitates connections to community services. If youth are not already connected to community services, direct referrals are made from the hospital rather than putting the onus on the youth or their family to contact outpatient services on their own. In other communities, we heard of adult psychiatric nurses following up with anyone who had attended the emergency room the night before.

"If the youth got the proper care the first time they were there, you're not there every second or third day."

- Child Welfare



The Advocate finds these initiatives very positive and in hospitals where these services are available, it works to reduce wait times. This aligns with the **MHAAP recommendation #4 to “reduce wait times, improve response in emergency departments for mental health and addictions issues, and improve transitions back to the community.”** Youth, parents/caregivers and psychiatrists suggested that such transition services be available to youth in all emergency departments. This step may prevent youth from falling through the cracks by ensuring there is a connection to services for the young person if needed.

“[P]rovincially, there aren’t enough beds because pretty well all of the units in Saskatoon, Regina and Prince Albert run over capacity. So that would give you an indication that we don’t have enough hospital beds.”

- Psychiatrist

4.4.1.2 MENTAL HEALTH INPATIENT FACILITIES

Mental health inpatient units are intended to provide services to children and youth aged 11 to 17 who are experiencing intense or acute mental health problems that interfere with their daily life. At the time of publication, there are three mental health inpatient units dedicated to children and youth in Saskatchewan located in Prince Albert, Saskatoon and Regina. Although each unit has 10 beds available, the unit in Prince Albert has reduced its capacity to 5 beds while attempting to recruit a child psychiatrist, leaving a combined provincial total of 25 active beds.

Some rural hospitals may also have a limited number of beds designated for psychiatric emergencies where youth can be admitted, usually on a temporary basis, and in some instances, youth can be admitted to hospital in a regular bed. From 2014/2015 to 2018/2019, there was an average of 1,839 hospitalizations of children and youth per year for mental health disorders in Saskatchewan.⁶⁸

NOT ENOUGH BEDS

“I have known individuals that have waited days in the hospital sitting in the waiting room without a bed or anything simply to be turned away because there’s no more room.”

- Youth Advisory Council

A foremost concern expressed by participants was that there are not enough inpatient beds available for children and youth who are in crisis and that this limitation is a primary driver behind young people in need not being admitted to an inpatient facility.

Our research found a disconnect in perspectives regarding the accessibility of inpatient treatment between management-level health officials and the lived experience of youth, their supporters, and the mental health professionals providing service. Some health management officials believed there was “good bed flow”, allowing units to make room for those youth coming through the emergency room that required admission.

⁶⁸ Canadian Institute for Health Information. (2020). Care for Children and Youth With Mental Disorders — Data Tables. Ottawa, ON: CIHI. (NOTE: This number is inclusive of children and youth who required multiple admissions and is not reflective of the total number of children hospitalized.)

However, health care practitioners across the province (psychiatrists and inpatient staff) reported that the number of inpatient beds is insufficient and that units are “always full.” Health management described the perils of running a unit overcapacity, as it results in a more confined space where young people can trigger each other, apply peer pressure, or trade maladaptive coping mechanisms. It also becomes harder to keep the younger patients away from older ones.

“Forecasting – so these are how many people are coming to [the emergency room], these are how many beds we have, these are how many people are being turned away. It’s not rocket science. It’s a business, so treat it as such. There needs to be more beds.”

- Parent/Caregiver

Additionally, offering specialized youth inpatient units in only three urban centres means that many youth must leave their communities to access treatment. Participants described the impact of how travelling away from their support systems, family, and friends can heighten their feelings of vulnerability and impede their treatment success.

Full inpatient units and travel barriers can result in young people being placed in adult psychiatric units. Numerous stakeholders – including youth and mental health professionals – expressed concerns regarding safety and the lack of specialized, child-centred treatment for children and youth in these facilities.

However, stakeholders from all groups, including health staff, expressed the need for more youth inpatient beds to provide meaningful intervention to those who require this level of service and to mitigate an escalation of the desperation youth experience that can ultimately lead to more severe, or even fatal, consequences.

“Speaking from the inpatient point of view, mostly we have adults on our unit and having youth come on sometimes is a concern just based off the dynamics of who’s there. [...] And then, trying to make sure that we service the youth, you know, doing groups and stuff like that at the same time trying to service our adults, it’s just tricky. [...] Always one of the number one concerns would be safety because some of our patients can, you know, be unpredictable, right?”

- Rural Health Staff

“I think we definitely need a youth ward that is just for youth and teenagers and that’s it. [...] Youth here are thrown in with the adults I find in this town. Not separated through anything. [...] We are very just thrown in with the adults and that, and with mental health I don’t think you should.”

- Youth



Participants indicated there is a significant need to develop an inpatient facility in northern Saskatchewan to avoid the need to displace northern youth so far from home for treatment. Several stakeholder groups called for an inpatient facility specifically geared towards Indigenous ways of healing and well-being. The Lac La Ronge Indian Band Wellness, Healing and Recovery Centre – currently in development – will be an important centre that will fill some of these gaps and promises to meet a significant need for holistic mental health and addictions services to local individuals “[...] regardless of ethnicity, gender or age.”⁶⁹

Stakeholders in corrections reported that a high percentage of youth in custody facilities have diagnosed or suspected mental health disorders. However, appropriate facilities do not exist in this province to meet their needs. We heard there is a need for youth to have access to court-ordered mental health beds, such as are available to adults at the Saskatchewan Hospital. Without this resource, youth’s mental health

needs are often expected to be managed within custody facilities by staff who reported feeling ill-equipped for the task, which can result in situations where youth experiencing mental distress are unnecessarily secluded or restrained for safety reasons.

*The United Nations Standard Minimum Rules for the Treatment of Prisoners*⁷⁰, known as the “the Mandela Rules”, call for a prohibition on the use of solitary confinement of individuals with mental disabilities when their conditions would be exacerbated by such measures. If the right of youth to facilities appropriate to the treatment and rehabilitation of their health are not respected, protected, and fulfilled, this can lead to increased harm to the young person. An alternative solution suggested by some participants was the development of a therapeutic mental health unit within youth correctional facilities, where appropriate interventions are provided by nursing and mental health professionals.

The Advocate recognizes that the province is making efforts to move toward a “stepped care approach” where individuals are matched to the care required in the most appropriate setting,⁷¹ and the most effective and least resource-intensive treatment is delivered first, before a more intensive, specialized service is needed. This approach aligns with international best practices calling for a shift away from long-stay mental health hospitals towards meeting individuals’ needs through a range of options.⁷²

The Story of Jess

“They just gave me a book and I had to answer the questions and then, if I screamed long enough, one of the nurses would come and sit there for a bit until I shut up. [...] I was the only young one in there with a bunch of older people. [...]

Maybe a children’s centre, I don’t know, something that you can work with the kids and not just put them in a room and hope that their problems will go away. [...] [W]hat would have been more helpful for me, in my perspective, is if I could be put with a group of kids with the same struggles. Kids I can relate to, because then [...] if you can relate to them, you can trust them because you know they’ve had it just as bad. If I could have seen other kids that struggle, I think if they would put us in a group and then taught us something, or gave us ways to deal with it, we could have bonded, we could have had ways to talk about it, and not just be alone.”

⁶⁹ Risom, L. (2020, November 23). ‘I get to build this great project’: Lac La Ronge Treatment Centre Construction provides local employment.” CTV News. (Retrieved from: <https://saskatoon.ctvnews.ca/i-get-to-build-this-great-project-lac-la-ronge-treatment-centre-construction-provides-local-employment-1.5201104>)

⁷⁰ United Nations General Assembly. (2015) United Nations Standard minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). Resolution 70/175, annex, adopted on 17 December 2015 (Retrieved from: <https://www.ohchr.org/Documents/ProfessionalInterest/NelsonMandelaRules.pdf>)

⁷¹ Government of Canada. (2020). Canada-Saskatchewan Home and Community Care and Mental Health and Addictions Services Funding Agreement. (Retrieved from: <https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/saskatchewan.html>)

⁷² World Health Organization. (2021). Comprehensive Mental Health Action Plan 2013-2020. Geneva, CH: Author. (Retrieved from: http://apps.who.int/iris/handle/10665/345301?search-result=true&query=comprehensive+mental+health+action+plan&scope=&rpp=10&sort_by=score&order=desc)

STABILIZATION VS RESOLVING ROOT CAUSE

“You don’t get fixed in a week or 2 weeks.”

- Corrections

Significant concerns were conveyed regarding an inpatient system that is used to temporarily stabilize youth and place them on medication, rather than address the underlying issues at the root of the problem or provide them with the skills needed to manage their mental health. Stakeholders stated that this approach – without a “stepped down” resource to facilitate a transition home – often leads to a revolving door of admissions. In the 2018/2019 fiscal year alone, there were 149 youth that required more than 3 hospital stays in a year.⁷³

“It was so clear what they were doing. They’re just putting you away because you’re a problem to the world. So that’s what it was. They just put you away in your room and hope that your problems go away over time.”

- Youth

“The one kid who I have seen the most successful in her hospitalization, it was probably her 15th or 16th stay that people were like, ‘Okay, we really got to figure it out this time.’ And that was over two years or something like that. But, I mean, should we really have to wait two years to get those resources?”

- Youth Shelter Staff

While some youth participants had positive experiences in inpatient care, many described the environment as inconducive to fostering mental well-being. Youth reported feeling alone, especially when the facility was far from their home community. Many equated these facilities to “jails”, citing unappetizing food, not enough family visits, “wearing the same pajamas for seven days”, stark environments and little to occupy their time. These concerns were especially prominent in communities without dedicated child/youth units and where youth are placed on an adult-wards.

These differing experiences highlight the value of seeking the opinions of youth on the programming that is provided. Standardized service delivery approaches may be effective for some youth and not for others.

Participants also reported that youth are generally being released from hospital too soon. We heard examples of youth being released before their medications were stabilized, while still having an active suicide plan or shortly after attempting suicide while still in hospital. Stakeholders indicated these young people were not ready to be discharged and, often, had to be re-admitted shortly thereafter.

“[T]here is absolutely nothing there that could help [my child]. Not one person. [...] It was just somewhere to go to keep her stable for a few days. They tried changing her meds and stuff in there, but they didn’t – like, they didn’t provide anything.”

- Parent/Caregiver

⁷³ Canadian Institute for Health Information. (2020). Care for Children and Youth With Mental Disorders — Data Tables. Ottawa, ON: CIHI.

"It's really hard leaving. I spent three weeks in there at one point and when I got out, I felt like I wasn't ready. I feel all the pressure was just thrown back onto me, like they give you coping strategies for when you get out of the hospital, but they don't really work on it a whole lot when you're in there."

- Youth

Numerous participants called for increased capacity to allow for longer-term inpatient stays with enhanced access to therapeutic programming, stating that stabilization and medication alone are not enough. We also heard there needs to be a stronger Indigenous cultural component in the treatment of youth in inpatient facilities that is consistent and available to youth admitted outside of the three dedicated child and youth inpatient units.

DISCHARGE PLANNING AND AFTERCARE

When youth are ready to be discharged, participants indicated that the process works best when their care plan is mapped out in advance and communicated to everyone involved in supporting the youth, outpatient appointments are scheduled prior to discharge and follow-up contact with youth is initiated by service providers. While inpatient staff are directed to ensure these things occur – and there are instances where they do – discharge planning and aftercare were viewed as inconsistent and often lacking the collaboration required to ensure a smooth transition home. This is particularly the case when inpatient units are facing high demand.

Many participants reported that:

- planning is not initiated early enough in a youth's stay, which can result in plans not being tailored to their needs;
- youth are not always consulted in the planning process;
- case conferences do not always occur, or are not coordinated until a youth has had multiple admissions;
- information is not always shared – or not shared in a timely manner – with other supports integral to supporting youth with their care plan, such as group home/youth shelter staff, corrections workers, educators and community mental health and addictions counsellors;
- rural hospitals without social workers are limited in their ability to address social issues that may impede a youth's progress after discharge; and,
- coordination of outpatient care is left to the youth or their caregivers, who feel they are being left to navigate the system on their own.

Collectively, these experiences convey that greater coordination across all sectors is required to ensure the best interests of the child are met at this crucial time in their lives.

"Because this [discharge from inpatient] was something that happened quite a few times [...], if it's cyclical or if it's happening over and over again, something is not working within that system."

- Community Organization

"They only stabilize them to the point where they think they may not kill themselves today. [...] And that's not quite good enough service for some of our kids. And then they are transitioned out and they are high risk and [they think] it's okay to have a doctor's appointment a week or two from now. But, I mean, they are transitioned out before they are ready to take that on. [...] They are cycled out."

- Child welfare

Inpatient staff and management described recent improvements and practices that, while not systematic, have proved beneficial, including:

- reserving two community counselling appointments per week for youth being discharged, and having the youth remain connected to that counsellor for ongoing treatment;
- having a community counsellor attend the inpatient facility to meet with youth prior to their discharge and maintain this connection following release;
- having a mental health nurse contact youth following discharge and between psychiatry appointments to follow up on medication management;
- having social workers on the unit to review a youth's circumstances and make efforts to address any barriers youth may face in returning home, such as abuse or neglect, lack of routine and structure or limited financial resources; and,
- facilitating regular communication between remote or northern health services and urban inpatient units to discuss discharge plans and connect youth with services in their community upon return.

These processes, if implemented consistently across the province wherever youth may be admitted, would help to address many of the concerns expressed by stakeholders. Additionally, at the time of our consultations, a significant barrier identified was the lack of an electronic health record in Mental Health and Addictions Services akin to what is available in primary health. Since that time, in alignment with a recommendation from the Provincial Auditor of Saskatchewan to establish a provincial integrated mental health record system,⁷⁴ the Mental Health and Addictions Information System (MHAIS) has been implemented across nearly all community mental health and addictions services in the province.⁷⁵ Additionally, the MHAIS is being used in the new youth addiction treatment centre in Swift Current which was developed in partnership between the Saskatchewan Health Authority and a community-based organization (CBO). The Ministry of Health indicates that sharing access to this record system with the CBO will provide a foundation for further expansion to other CBO partners.

"We had him back and forth to the hospital numerous times, but they kept releasing him back to us. And, finally, I think the last time we had him in there we asked for a consult with the psychiatrist and that was probably the best thing that happened – when he was able to give us some strategies as to how to deal with that. So, better communication with the hospital would be, certainly, a bonus – with them providing us a more concrete discharge plan."

- Corrections

⁷⁴ Provincial Auditor of Saskatchewan. (2018). Report of the Provincial Auditor to the Legislative Assembly of Saskatchewan: 2018 Report – Volume 1. Regina, SK: Author.

⁷⁵ At the time of writing, it had not yet been implemented in Regina.

"[I]f we're discharging it should be smooth at that point, right? We should have a place where they're going, we should have supports set in place for them, so that we're meeting their needs and they can be best successful in the community, not requiring the service again."

- Mental Health Official

It is also being piloted in two adult mental health inpatient facilities, allowing community providers to access information from an adult's stay in those inpatient facilities. The Ministry of Health reports that there is a long-range goal for all hospital/inpatient and community services to use this system.

Stakeholders within and outside of health conveyed the importance of having standardized discharge planning processes across the province to ensure a more proactive and immediate connection with outside supports – including within adult or rural facilities that provide inpatient services to youth. It was suggested by some that a navigator be assigned to each youth transitioning from inpatient to community services who can prepare the youth and family for the transition and provide follow-up support to ensure their various needs are being met.

Some stakeholders suggested these services be expanded to include nurses attending the homes of youth patients to ensure appropriate medication compliance, such as what is available to adults. If a young person is not set up for success at discharge from hospital, there is a significant risk of losing all the progress made during treatment.

Safety planning for suicidal youth was identified as a particular area of concern. Youth are typically asked to identify two people to call when needing support. However, we heard these individuals are often not informed of the plan or how to respond if the youth does reach out. Additionally, youth who rely on app-based communication are unable to contact their adult supporter if the app is not shared with the adult or if there is no Wi-fi to use it. Youth also reported not understanding their safety plan, stating the need to have, "Someone to actually show us how to do it, instead of just giving us a safety plan and [saying] 'Here's a piece of paper. Enjoy your day'." These issues must be problem-solved prior to discharge.

What is evident here is the critical importance of *meaningfully* including young people in the safety planning process and adequately informing everyone involved in supporting it. This is essential to ensuring its successful implementation, lowering the young person's risk of harm and ideally, preventing them from ending up back in hospital in the future.

4.4.1.3 GAPS IN THE STEPPED CARE APPROACH: LACK OF MIDDLE-TIER CARE AND RESPITE SERVICES FOR MENTAL HEALTH

Psychiatrists have stated that – in many cases – the primary needs of youth presenting at emergency departments in mental health crisis are not psychiatric. Rather, from their assessment, these young people are experiencing a combination of social stressors coupled with maladaptive coping skills. For some youth in crisis, the medical services provided within psychiatric inpatient units may not be what is needed. For others, a brief stabilization period under the care of a psychiatrist may be all that is required, provided youth have appropriate and continued supports following discharge that work to address their social needs and build resilience and healthy coping skills.

"I had somebody on my list and then I called them one time when I was feeling suicidal, and turns out they did nothing to help, because [they said] 'Oh, I am in the exact same position. Like, I can't help you.'"

- Youth

The crux of this issue is that this support, such as a "middle-tier" care, is not sufficiently available. Although many stakeholders called for more inpatient beds or longer stays in inpatient units, these pleas may be coming from a lack of awareness of other possible options. This discussion highlights a gap in the ability of Saskatchewan's continuum of mental health services to meet the needs of youth who *may not require* – or who *may no longer require* – acute psychiatric treatment in an inpatient unit, but who may still benefit from more intensive, 24-hour, rehabilitative support than can be received at home.

As indicated earlier, youth struggle when released from an emergency room without what they believe to be adequate support. Many also struggle with the transition from an inpatient psychiatric unit which, at the very least, offers constant supervision, to then seeing a community counsellor or psychiatrist once every few weeks or months.

While we note there are some organizations in Saskatchewan that provide a residential alternative for youth with complex needs, families are often left in the untenable position of either having to pay high fees or relinquish their child to the care of the Minister of Social Services. For example, Ranch Ehrlo is a well-resourced and effective residential program serving children and youth, 97% of whom have identified mental health needs.⁷⁶ It provides a range of services including psychiatric care, individual, group and family counselling, speech and language pathology, occupational therapy as well as equine and art therapy. However, this is a private, high-cost, fee-for-service resource that can typically only be accessed by paying privately or through involvement with the child protection system.

"So, when we are sitting in an ER room waiting to talk to a doctor, [about] what a plan could be, or how to make sure that they can go to a place of safety, but then there is another barrier, right? Not many people will take a kid that is harming themselves or don't know how to deal with cutting or giving them coping skills right? Like, I can go on, and on."

- Child Welfare

76 Ranch Ehrlo Society. (2021). Outcomes 2020-2021. Regina, SK: Author (Retrieved from: https://ehrlo.com/pub/ehrlo-society/docs/reports/2021/2020_21%20outcomes_sm%20for%20website.pdf)

The Story of Waylon

When his mother requested a mental health group home for her son - after his third admission to psychiatric inpatient unit - she was advised this type of resource did not exist and the only resource the Ministry of Social Services could offer was a youth shelter which was only an emergency shelter with short term stays of under 30 days.

If unable to pay privately, parents of children under 12 years old can sign an agreement under section 9 of *The Child and Family Services Act* indicating that they are “unable” to care for their child because of their special needs. The intent of this section is to provide support to families by recognizing the desire to care for their children at the same time as their limited capacity to meet their needs at that moment. However, parents should not have to put their children in the care of the Minister to access health services. For youth over 16 to receive this support from the Ministry of Social Services, the youth must sign an agreement declaring that their parents are not “willing” to care for them or that they “cannot be re-established with [their] family”. There is a substantial difference between a family being unable and unwilling to care for their child. This should not be a position families have to take to receive health services, and is not required when youth need medical care for impermanent physical conditions.

When collecting our primary data, staff in available residential resources such as youth shelters and group homes explained that their programs did not have the capacity or training to accept youth with complex mental health needs. These organizations often feel youth are discharged to them from hospital care prematurely because it is assumed these youth are safe under the organization’s supervision. However, these resources report that these youth “need more professional help than what [they] can provide.”

Officials in health also expressed concerns related to the lack of an accessible transitional resource, stating that the hesitancy of group homes and shelters to accept youth with self-harming or suicidal behaviours is a barrier their system faces in ensuring appropriate placement for young people upon discharge. Psychiatrists stated that sometimes youth are kept on an inpatient unit longer than is required simply because their family is unable to support them and/or these youth have nowhere else to go. As a result, other youth who need acute inpatient care are prevented from accessing a bed. This gap in middle-tier care can have devastating and far-reaching consequences for young people and their life trajectories:

“We should have a place that we can go. Like a home away from home. Like the Ronald McDonald House, but for the mentally ill.”

- Youth

“There’s no housing for these youth who can’t go home because their parents can’t handle them, so they end up in Eagles Nest and that’s not ideal. Or they end up in Regina at Ranch Ehrlo which is far away from home, or they eventually end up in custody. And that’s not where mental health should be treated, either. So [...] I think we’re criminalizing mental health behaviour in a lot of youth that just need the support.”

- Corrections

Participants also identified a need for more temporary respite options for youth with mental health challenges. Supporting children and taking them to appointments put significant pressure on caregivers and can make it difficult for them to work outside the home, care for and engage with their other children and care for themselves. Parents stated the lack of respite resources prevents them from accessing their own services due to the fear of leaving their child alone. Many parents reported taking stress leave from their job or using up their vacation leave due to these pressures. In some cases, parents have had to give up their parental rights to access the services and supports required for their child, such as those provided through existing intensive residential care programs.

“When you don’t have that break, it creates... to the point where other people are having mental health issues in the home, because they’re overwhelmed.”

- Parent/Caregiver

Since our stakeholder consultations, the Ministry of Health and the Saskatchewan Health Authority have taken steps to address these gaps through the creation of youth-specific Community Recovery Teams. These teams consist of mental health nurses and addictions counsellors meant to be embedded in existing youth residential programs serving vulnerable youth in Regina and Saskatoon,⁷⁷ with a future location in development in Prince Albert. Funding for these teams from the Canada-Saskatchewan Bilateral Funding Agreement. Saskatchewan’s Action Plan to this agreement recognizes that “the establishment of residential options that include intensive supports for individuals with serious and persistent mental health issues will improve client outcomes and overall quality of life while addressing health system priorities related to reducing hospitalizations, length of stays and inappropriate presentations to emergency departments.”⁷⁸ To this end, the Action Plan states that these investments will target the **MHAAP recommendation to “ensur[e] a stepped care approach to mental health and addictions where individuals are matched to the care they need, in the most appropriate setting.”**

The Advocate is encouraged by this important step to increase the capacity of these community organizations to meet the needs of the vulnerable youth who access their programs. However, many placements in these resources continue to hinge on involvement with the child protection system, rather than being provided through the lens of a health service, and may not be able to offer the level of therapeutic care required by some youth.

Another recent development that appears promising is the creation of Egadz’s “The Retreat”, which is supported by the provincial government and the Saskatchewan Health Authority. The Retreat is a 5-bed home in Saskatoon meant to provide 24-hour support to female youth between the ages of 12 – 18, who are struggling with high mental health or addictions-related needs.⁷⁹ Access to The Retreat is limited, as there is only one location in the province, and it prioritizes female youth in care. There is no similar resource for male youth. Often running at capacity, it is clear this is a much-needed resource, but it remains inaccessible to many youth in Saskatchewan.

There was a clear call for residence alternatives that can bridge the gap between inpatient and outpatient mental health (and addictions) services for youth whose needs are more than can be supported at home. When asked what was needed, participants suggested more therapeutic homes staffed on a 24-hour basis with individuals trained to support youth with high mental health needs. Placements such as these would provide therapy, assistance with taking medication, skills training and crisis planning for both the youth and their family, as well as facilitate connections with other resources.

⁷⁷ These teams work with youth through Street Culture Inc. in Regina and Egadz in Saskatoon.

⁷⁸ Government of Canada. (2018). Annex 2 to the Agreement: Saskatchewan Action Plan on Home and Community Care and Mental Health and Addictions. Canada-Saskatchewan Home and Community Care and Mental Health and Addictions Services Funding Agreement. (Retrieved from: <https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/saskatchewan.html>)

⁷⁹ Egadz Website: https://www.egadz.ca/programs/baby_steps___michaels_place.html

Stakeholders called for a middle-tiered resource to function as:

- a longer-term placement, such as a 90-day recovery home for youth leaving inpatient treatment or custody;
- a temporary respite for families who are struggling to meet their children's needs, but do not want to relinquish them to the care of the Minister of Social Services; and
- a safe option for youth needing a temporary reprieve from their home environment.

**MHAAP System Goal:
Enhance Access and Capacity
and Support Recovery in
Community**

5. Increase community capacity to support people living with persistent and complex mental health and addictions issues, including housing and intensive team-based supports.

5.1 Enhance supportive housing options available in the community and ensure appropriate intensive team-based supports accompany their development.

Youth have unique needs regarding housing. Youth with complex needs require a living situation that enables them to acquire an education, as well as social and vocational skills, while having their treatment needs met through behavioural, mental health and addictions support. At the same time, their residential care requirements must be met, including respite, stabilization, assessment, and planning for transition back to the community.

"I have family issues at home and there is a lot of temptation to just want to run away. At least be somewhere by myself or with people who are not my family. So, I think that it could be like a whole facility to give me a break. A place to spend the night. Not having a lot of negative stigmas around that."

- Youth

For youth in care, these resources could assist in avoiding the trauma caused by multiple moves resulting from placements breaking down when their needs are outside the capabilities of caregivers.

Stakeholders indicated these residence alternatives should be less restrictive than inpatient treatment, while still providing support to youth in adjusting to the "outside world" by putting coping mechanisms into practice before being re-exposed to the various triggers faced in their everyday lives.

"You don't get to go to the outside world and, like, get how to deal with things. Because that [inpatient facility] is nothing like outside. [...] Like, in there, people are always nice to you. They always talk to you. But it's not like that in the real world. People are always gonna be mean to you and always gonna put you down. And being there doesn't help. [...] Like, in there, they take away everything like sharps, strings. But as soon as you get outside, you have access to all those things."

- Youth

"[T]hey don't practice with you really. They kinda just make you do a safety plan. Like sure, I can write down all these things that I might do if I'm feeling suicidal, but in the end game, I'm going to be overtaken by the things inside of me and I'm not going to look at my coping strategies."

- Youth

Stakeholders also called for a respite option that would have parent aids or respite workers come into a youth's home to temporarily assist their family in meeting their needs during times of crisis and/or after release from an emergency department or inpatient facility. It was stated that it is important that this support be accessible without a family having to become involved in the child protection system.

These supports are critical for parents/caregivers to avoid entrenchment in the child welfare system and should be cost-shared by both the health and social services system, not shouldered solely by the Ministry of Social Services.

These health supports would align with direction given by the Committee on the Rights of the Child in its **General Comment No. 15 on the right to the highest attainable standard of health** that it is in the best interests of all children to be cared for in community and family settings, "with the necessary supports made available to the family and the child";⁸⁰ and that placement of young people with psychosocial disabilities in a hospital or institution should only be considered when this is not possible. It would also fill a gap in the province's "stepped care approach" by supporting youth with mental health problems to live with their families.

There is a moral, social and legal obligation for the government to ensure that children are well cared for, and this includes their mental wellness. Saskatchewan is far from protecting the right of children to the highest attainable standard of health if it does not provide "facilities for the treatment of illness and rehabilitation of health" for young people, that is, at minimum, commensurate to services for adults.

4.4.2 Addictions – Detox and Inpatient Treatment

"[I]f they are saying 'I want to change' that might only last a few minutes. So, you really need to be able to respond and get the right response right then and there."

- Child Welfare

UNCRC Article 33

States Parties shall take all appropriate measures, including legislative, administrative, social, and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Just as the United Nations Convention on the Rights of the Child (UNCRC) guarantees to children and youth the right to the highest attainable standard of health and access to health services, it also specifically requires governments to take measures to protect young people from illicit use of drugs. Despite this very clear responsibility, there was consensus among stakeholder groups that support options for young people battling addictions are extremely limited.

In addition to the barriers discussed in relation to community addictions counselling, participants also expressed concerns with the availability, accessibility and efficacy of detox facilities and inpatient treatment, and the detrimental impacts these barriers can have on a young person's success.

Many of these structural obstacles parallel those identified in relation to mental health hospital and inpatient services, but their impact on youth struggling with addiction is unique. As substance misuse and mental health issues are often co-occurring,⁸¹ the magnitude of the cumulative effects these barriers have on young people is devastating.

⁸⁰ UN Committee on the Rights of the Child (CRC). (2013). General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (Article 24). 17 April 2013, CRC/C/GC/15. pp. 8. (Retrieved from: <https://www.refworld.org/docid/51ef9e134.html>). pp. 3

⁸¹ Canadian Centre on Substance Use and Addiction & Ontario Centre of Excellence for Child and Youth Mental Health. (2013). When Mental Health and Substance Abuse Problems Collide. Ottawa: Author (Retrieved from: <https://www.ccsa.ca/when-mental-health-and-substance-abuse-problems-collide-topic-summary>)

4.4.2.1 DETOX

The intent of the detoxification period is to allow time for chemical substance(s) to leave a youth's body, stabilize their health and prepare them for ongoing treatment following discharge. Several "social" detox beds are in place in hospitals across the province where youth can voluntarily undergo this process.

In 2006, *The Youth Drug Detoxification and Stabilization Act* (YDDSA) was enacted, permitting the involuntary detention of youth aged 12 to 17 years for the purpose of detoxification in a secure facility for up to 15 days, or at a safe place in their home community for up to 30 days. For this to occur, a judge must issue a warrant to apprehend the youth for assessment. Two separate physicians must agree the youth is experiencing severe drug and/or alcohol addiction and requires confinement to protect their health and safety. Youth are to be informed of their rights during this process and can appeal the physicians' decisions. Any addictions services following detoxification, including inpatient treatment or outpatient counselling, are voluntary.

This legislation was identified by stakeholders as a useful tool in recognizing addiction as distinct from criminality and preventing the unnecessary entrance of many young people into the justice system. Additionally, it offers an opportunity to stabilize those youth who – because of either their addiction or a combination of other complex life circumstances – are unwilling or unable to seek treatment on their own. However, as this process infringes upon the rights and freedoms of young people, it must only be used with due cause and as a last resort. The process must run smoothly and minimize further trauma and disruption to their lives. Furthermore, it is imperative that, when used, secure detox and follow-up care be effective to avoid the need for further detention.

However, participants indicated that this is not always the case, describing the process of obtaining a detox order as cumbersome and resulting in delayed access to warrants or assessments – stating that:

- substance-related crises often occur outside of regular business hours, and it can be difficult to find an available judge;
- there are limited physicians in the province with both the capacity and willingness to conduct an assessment;
- there is a lack of awareness of which physicians can fulfill this role in various communities, especially in rural areas;
- it can be a challenge to transport the youth to an urban centre for assessment; and,
- youth are often required to wait long periods of time in an emergency room prior to being assessed.

"I think if addictions services were closer to people, they would want to get clean more because it would be easier to make the choice."

- Youth

The consequences of these delays are many. When in an active state of substance misuse, individuals can be a danger to themselves or others and require timely action. Long waits in emergency departments while under the influence of alcohol or drugs can be difficult, or even traumatic, for youth and their supporters. We heard from a parent who described needing three guards to restrain their child while waiting for an assessment. This is not an uncommon experience. Additionally, if the wait is too long, the substance can leave the young person's body, making a detox order difficult to obtain. In the absence of an acute presentation, psychiatrists expressed frustration with having no other services to provide immediate support to youth.

To mitigate the long waits and risk associated with not meeting the criteria for admission, participants suggested that increasing physician capacity to conduct assessments, and a more streamlined process for judicial officers to identify and contact physicians once a warrant was issued were needed.

The lone secure detox facility in the province is in Regina. As it is not centrally positioned in the province, stakeholders reported that it is inaccessible to many young people, particularly those from the North. Their concerns are evidenced by the fact that youth from the (former) Regina Qu'Appelle Health Region consistently make up approximately 60% of admissions to the secure detox facility.⁸²

While the YDDSA allows for youth to be held at any acute care facility, there is no access to the specialized programming that is available in secure youth detox in Regina. Furthermore, the use of beds in adult treatment facilities is not ideal for the same reasons as were discussed in relation to youth being placed in adult inpatient mental health units. These statistics indicate that the right of young people to an equal standard of care and services – regardless of residency in the province – is not being fulfilled. The Ministry of Health reports there is currently a wait of less than one week to access the secure detox facility.⁸³

For youth willing to attend voluntary stabilization, stakeholders reported that – while some have been able to get a bed immediately – others have had to wait weeks. While waiting, the young person may lose the motivation to seek help and/or fall deeper into their addiction. Group home operators and custody staff indicated youth are often placed in or returned to the home while under the influence of substances due to the lack of detox spaces available in or near their community. In these situations, the staff or group home operators stated not feeling properly equipped to care for youth in these circumstances.

Stakeholders also expressed concerns about the length of secure detox services. The maximum allowable admission to secure detox under the YDDSA is 15 days. This issue was most often raised in relation to the use of crystal meth. Professionals working with youth felt this was not enough time for youth to reach a stable enough point at which aftercare options can be presented to them. If youth are not sufficiently detoxed prior to discharge, there is a decreased chance the youth will voluntarily access either inpatient or outpatient treatment. Several judges across the province described seeing youth repeatedly return to substance use following their discharge, resulting in subsequent detox warrants being issued.

⁸² The Youth Drug Detoxification and Stabilization Act Quarterly Reports 2018-2021 (Provided to SACY by the Ministry of Health and the Saskatchewan Health Authority)
⁸³ Email Communication from Ministry of Health to Advocate for Children and Youth, 13 January 2022.

4.4.2.2 INPATIENT ADDICTIONS TREATMENT

Young people often ask for help addressing their problematic substance use or addiction only when at their lowest point. This takes immense courage. If faced with barriers at this juncture, any potential for positive outcomes can be derailed.

NOT ENOUGH TREATMENT BEDS

As addictions treatment (outside of secure detox) is voluntary, stakeholders emphasized the importance of services being available when young people are ready and willing to engage with them. Youth are most receptive to further treatment immediately following detox, and this window of opportunity is very small. Accordingly, there must be a seamless transition between detox and inpatient treatment. When there is a gap, youth are vulnerable to relapse. This also applies when youth seek inpatient treatment without having first gone to detox.

Health officials report that there are currently little to no wait times for youth inpatient addictions treatment and that transitions between voluntary detox and inpatient treatment are often immediate.⁸⁴ Yet, stakeholders reported that many young people have had to wait for access to inpatient treatment. At the time we collected our primary data, there were two provincially operated youth inpatient treatment centres, located in Saskatoon and Prince Albert. Stakeholders indicated this was not enough. Since that time, a new 6-bed unit was opened in Swift Current in partnership with a community-based organization.

The Advocate is encouraged by this positive step toward addressing the concerns reported from stakeholders. However, given the increasing impact of crystal meth and opioid use in Saskatchewan, the province must continually evaluate the number of available beds against the need for inpatient services, and the geographical locations in which these are required. The disconnect between the placement of secure detox in Regina, when there is no inpatient treatment centre in that city, was identified by participants as a barrier in transitioning from one service to the other.

More spaces and/or expanded geographical distribution in both detox and inpatient treatment would allow the system to respond immediately to youth and offer the service needed at the time the young person is ready and willing to receive it. Ensuring seamless transitions between detox and inpatient treatment will capitalize on a youth's ability to meaningfully participate in treatment before getting drawn back into the cycle of substance misuse and addiction.

"What do you do after detox? Because you go and get detoxed, but you can't get into treatment. So then by the time treatment's got a bed for you, you need detox again before you can go back into treatment. So, it's this vicious circle."

- Parent/Caregiver

"I know the wait times to get kids help is awful, and I think that's not fair. They don't have that willpower to stay clean one more day."

- Parent/Caregiver

84 Email Communication from Ministry of Health to Advocate for Children and Youth, 13 January 2022

I get very homesick [...] so, when I was in Calder it was kind of far and that kind of got in the way of what I was trying to do when I was in there.

- Youth

As a disproportionate percentage of youth struggling with addiction are Indigenous, Indigenous stakeholders conveyed it was important for these treatment centres to be on the land and provide a stronger cultural component than what was described as the piece-meal approach currently offered in inpatient treatment. The Lac La Ronge Indian Band Wellness, Healing and Recovery Centre currently in development received a portion of its funding from the Saskatchewan Ministry of Health and is a welcome addition to the service continuum, as it promises to meet a significant need for both addictions and mental health services to all residents of northern Saskatchewan "[...] regardless of ethnicity, gender or age."⁸⁵

LENGTH AND FLEXIBILITY

The Ministry of Health states that the length of addictions inpatient treatment is based on the needs of the client, and not an enforced maximum treatment duration. However, numerous participants perceived the average admission of four to six weeks as insufficient to address the substances youth are currently using, especially crystal meth.

We also heard more flexibility in rules and standards within treatment facilities is required to facilitate youth's success. Participants indicated that many young people leave treatment early due to feelings of loneliness exacerbated by restrictions around contact with friends and family. Additionally, akin to the comments made related to mental health inpatient units, youth described treatment centres as feeling "clinical", "institutional" and "like a jail". Several youth and other stakeholders also described an unwillingness to attend a treatment centre that did not allow smoking. Additionally, significant concerns were raised with the lack of "forgiveness" afforded to youth during treatment. It is well known that addiction is a disease, of which relapses, "slips" and impulsive behaviour are common symptoms.

According to the Canadian Centre on Substance Use and Addiction, "addiction is characterized by inability to consistently abstain [and] impairment in behavioural control". Furthermore, "like other chronic diseases, addiction often involves cycles of relapse and remission."⁸⁶ However, many participants stated that inpatient facilities do not give youth opportunities "to be kids and have those slips". We heard of youth being turned away from treatment upon arrival for having drugs in their possession, rather than simply confiscating the substance, and allowing the youth to stay and address the issues. Group home operators indicated that none of their youth had ever been able to complete the program.

85 Risom, L. (2020, November 23). 'I get to build this great project': Lac La Ronge Treatment Centre Construction provides local employment." CTV News. (Retrieved from: <https://saskatoon.ctvnews.ca/i-get-to-build-this-great-project-lac-la-ronge-treatment-centre-construction-provides-local-employment-1.5201104>)

86 Canadian Centre on Substance Use and Addiction. (2017). Moving Toward a Recovery Oriented System of Care: A Resource for Service Providers and Decision Makers. Ottawa, Ont.: Author. pp. 23 (Retrieved from: <https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Recovery-Oriented-System-of-Care-Resource-2017-en.pdf>)

"They can't treat them the same as adults. [...] Kids make mistakes all the time – that's how they learn. So, I think that our facilities need to reinforce that and not penalize them."

- Child Welfare

"It's just too many rules and guidelines and standards that almost make it impossible for kids and young people to be successful [...] right? Cause there's so many barriers, it's like, you know, you screw up here, you're out [...] you screw up there, you're out."

- Group Home Operator

The Advocate acknowledges and is aware that certain safeguards are necessary. Health officials explained these measures are intended to "protect the youth as much as we can because they are in a vulnerable state." However, it may be that more consideration around these expectations is required in consultation with young people. Participants felt that youth needed to be met with additional support, rather than severe consequences.

Numerous participants also called for mandatory inpatient treatment. However, my office emphasizes the obligation to balance the need to address addiction-related harms with respecting the rights and freedoms of young people. Nonetheless, a focus on improving detox and treatment services alone will not be effective to fulfill the government's obligation to protect children and youth from the misuse and abuse of illicit drugs. There must also be more done to address the social and environmental factors that lead young people to substance misuse and addiction in the first place. We must rectify the root causes, rather than just treat the symptoms. Proactively addressing the issue via early intervention strategies and investment in both inpatient and community services will mitigate long-term serious use when that young person becomes an adult.

DISCHARGE PLANNING AND AFTERCARE

Participants were emphatic that appropriate planning for and delivery of aftercare services following an admission to a detox and/or inpatient facility is critical to a young person's success in overcoming addiction. Youth must have adequate support to apply the skills learned and maintain the progress made. The lack of transitional resources across the province to support aftercare can increase a young person's risk of relapse.

Participants identified concerns surrounding release from addictions treatment that paralleled those discussed in the section on emergency rooms and mental health inpatient units. It seems the same gaps exist in:

- discharge planning;
- information-sharing; and,
- connection to/follow-up by appropriate community counselling services.

In addition to improved communication and collaboration, stakeholders indicated that a more "gradual release of responsibility" is required for youth being discharged from addictions inpatient treatment. Stakeholders stated that longer-term, therapeutic follow-up with youth by counsellors and/or mentors is needed at the crucial juncture where the young person is more open to change.

"I went [to addictions treatment] once but, I don't know, it just really didn't help. 'Cause I went back to the same thing. It helped me because it got me sober and stuff, right? But after that, I went back to the same thing, because I was with the same people."

- Youth

Youth participants and other stakeholders also identified a need for peer/ group support around addictions issues, such as Alcoholics Anonymous and Narcotics Anonymous groups targeted specifically at youth. There are many communities in which these programs are not available. If these are available, youth described being uncomfortable attending with adults.

"There's a lot of young people in our community committing suicide and drinking. I see a lot of drinking. Young kids. I think they should have AA roundups and things like that for the youth. I don't know, get the youth all together and that and have an Elder talk with them. I think that's why so many kids are turning to alcohol – because no one's there for them or they feel alone. Or like, nothing going on in the community, like no hang out place, nothing."

- Youth

We also heard there is not adequate consideration of a youth's immediate needs upon discharge or how to best be supportive to help a young person maintain sobriety. While youth may be successful during the period of detox, inpatient addictions treatment or even custody, youth and other stakeholders stated this progress often breaks down upon return to the same environment where the young person continues to experience the same pressures, traumas, triggers and access to substances.

For youth who are returning home, we heard that more intensive family counselling is needed to help all members heal from any discord either contributing to, or arising from, the addiction. It was suggested there is a need for expanded residential programs that treat the whole family, because "the environment has to change – not just the mental state of the [young] person." If youth do not have a stable environment to return to, this leads to transiency and difficulty in maintaining the structure and routines developed in treatment.

As discussed in relation to mental health, there is also a lack of adequate accommodation options for youth struggling with addictions issues. Again, participants expressed concern that parents may have to put their children in care to access the supportive services required.

"[Due to] high risk to abusive substances to the point of overdosing, mom had to basically sign a Section 9⁸⁷ to get him into the ministry because she was afraid he was just going to kill himself overdosing because he was substance-seeking so hard. And, yeah, it became a Ministry problem. [...] There's lots of kids that that happens. Like, the parents feel like they don't have any other options for support for their children, so they just sign them over to the Ministry because that's all they're left with."

- Corrections

Unfortunately, even out-of-home care placements often break down. We heard that youth with addictions issues are not always a fit for available placements and may have difficulty adapting to strict rules, or the caregiver may not be prepared to manage their needs. This is especially relevant in cases where the length of treatment was not sufficient to fully equip youth with the skills needed to stay on track.

⁸⁷ An "Agreement for Residential Services" under Section 9 of The Child and Family Services Act allows parents to voluntarily place their child in the care of the Minister of Social Services when unable to meet the child's needs. Provincial policy states that Section 9 Agreements are only to be used when parental issues can be resolved quickly and the case plan is for the child to be returned home.

"[They] have tended to be couch surfers because there's no place to go. Not good rule followers, if you put them in a place with a whole bunch of rules – curfew's this time, no music, no drugs, no smoking, nobody in your room, blah, blah, blah – they blow out within the first week they're there, right? I think there's a place that could be developed that could manage those kinds of kids, but it can't be our traditional template."

- Child Welfare

"You just can't go to treatment and it's not a cure. It gives you the tools, but it's still up to you to use them and how to cope with your cravings and all that."

- Youth Shelter

Parallel to calls for "middle-tier care" to be added to the continuum of youth mental health services, participants are calling for a residential alternative for youth recovering from addiction who do not need the intensive 24-hour supervision of an inpatient treatment centre, but who do require a safe environment to receive ongoing support and to mitigate triggers and temptations related to relapse. Especially as mental health disorders and addiction are often co-occurring, the development of such a resource that could support youth with both is sorely required.

4.5 Lack of Integrated Services

"We need to be able to work together to help kids."

- Corrections

There are often many stakeholders involved in the life of a child who are supporting their well-being, positive development and best interests. In addition to parents/ caregivers, this network can include multiple mandated government service providers, such as those in various roles in health care, child welfare, justice and education.

This shared responsibility is consistent with the government's obligations under Article 6 of the UNCRC to "ensure to the maximum extent possible the survival and development of the child", and under Article 8 "to render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities". The concept of "development" ought to be interpreted in its broadest sense, encompassing the child's physical, mental, spiritual, moral, psychological and social development. It is, therefore, critical that all child-serving systems work together in the best interests of the child.

"I think the way it is now it's like, 'No, this isn't our deal, it's Social Services'. Or we're like, 'This isn't our deal, it's mental health.' Right? And I don't think we're getting anywhere with that perspective."

- Child welfare

Many children and youth who need help are "falling through the cracks", because their specific circumstances do not fit the mandates of the various provincial child-serving systems. Service providers report being limited in their ability to intervene under their individual mandates, and simply hope that the child is caught by another system. In cases where this does not occur, children and youth are left with no support at all, widening the barrier to addressing their mental health needs.



"[I]t's very difficult to engage now when people have already, sort, of 'blindness' on – and within their own mandates. I hate mandates. Mandates tell me that there's something I need to break down, because we have a collective mandate – and that's our population within the province."

- Mental Health Official

4.5.1 Lack of Communication and Coordination Within the Health System

Stakeholders in every sector identified the lack of communication, collaboration and coordination as a significant barrier to children and youth receiving the mental health and addictions support required. The lack of communication and coordination was also identified as a core issue in our investigation into the services to Waylon. The former health regions amalgamated into the Saskatchewan Health Authority in 2017. At that time, stakeholders in various sectors were optimistic that this transition would result in more streamlined and consistent service provision and improved integration and information-sharing across the province. While there have been improvements in some respects – this reality has not fully materialized.

Mental health and addictions staff stated there is simply no time to engage in building strong pathways between services. Despite the move to one "health authority", providers across the province expressed being unfamiliar with what each region provides in terms of services or catchment. It was reported that some providers are still "very set in their boundaries" and it "depends on who you get on the phone" as to whether a young person will gain access to a service in another area.

Participants also stated there is often a disconnect between specialist services that fly to northern communities in the wake of crisis and the frontline providers in the closest urban areas that are also servicing those communities.

"I think our services for children, specifically across [our city], are very fragmented. We're kind of in different areas where we often see multiple people and, if we could have services specific to the children under, kind of, one roof or one area, it would be much easier for families to access services, for the staff to collaborate and plan for what a family might need, with a range of services."

-Mental Health and Addictions

In contrast, in communities where mental health and addictions counsellors were co-located, this was identified as a significant benefit to providing better coordinated services to youth with concurrent conditions. Stakeholders stated these benefits are amplified further when combined with other services, such as psychiatrists, psychologists, social workers, and Elders, as it facilitates cross-consultation.

"[W]e all work together. We are supporting each other. We are accountable to each other. Not just psychiatrists – the social workers, nurses...then you can see the output is significantly higher. If we all sat differently in our offices and mental health therapists in their offices, then we will have a very different outcome here."

- Psychiatrist

"There has to be a link between all of these services involved in some way so that we can share information."

- Psychiatrist

"[T]he whole co-morbidity with substance use and mental health disorders is astronomical. So being here and being in the same building with all of the other professionals that have their own specialty has been the best thing for collaborative work – like joint appointments. I can walk down the hall, knock on the psychologist's, the psychiatrist's office. They come to us too. Like, when a psychiatrist came to my office – I almost fell out of my chair [...] to ask me my thoughts on a kiddo, which never happened before we became part of this building."

- Addictions Counsellor

"Speaking as more in the psych role, I didn't have as much training in addictions. I am just thinking of a specific case where a kiddo...I had built a strong relationship with him, and he was struggling with addictions, and it was quite unsafe. He wasn't comfortable or open to working with an addictions counsellor, so then I just walked a few offices over and did some consultation and then was able to [...] efficiently bring that over – and that made a big difference in the treatment plan. [...] I think I would have been a lot less confident in my approach moving forward if I was just stuck with Google."

- Psychologist

To this end, the Government of Saskatchewan recently announced that it is moving forward with an Integrated Youth Services project, which would see several services co-located in up to three communities. These services would include, but not be limited to, mental health and substance misuse services, youth and family peer support, primary care, social services and other services as identified by community need.⁸⁸

Other examples of recent collaborative efforts identified as helpful in the pursuit of holistic child and youth health included:

- the movement to integrate mental health and addictions into primary health care;
- the inclusion of autism services and speech and language pathology under the mental health umbrella in some regions;
- a pilot project in which nurse practitioners and public health practitioners were placed in schools to deliver wellness programs around various health risks, including those impacting mental health; and,
- the development of the Division of Social Paediatrics in Saskatoon.

Stakeholders further suggested that to achieve greater internal connectivity within the health system, many participants felt it would be of great benefit if all services essential to a child's mental and emotional well-being were linked and accountable to each other. This could include expanding the approach of co-locating services to children and youth to better facilitate face-to-face communication and consultation

⁸⁸ Government of Saskatchewan. Integrated Youth Services. Regina, SK: Author. (Retrieved from: <https://www.saskatchewan.ca/residents/family-and-social-support/integrated-youth-services>)

Division of Social Paediatrics

Established in Saskatoon to address disparities in healthcare for children and youth from low-income families, the operational model of this initiative is unique as it incorporates partnership between organizations that are outside of the health system, yet integral to child and youth well-being. The Division partners with the Saskatoon Tribal Council and the Greater Saskatoon Catholic School Division to operate school-based health clinics aimed at providing multidisciplinary services. Staff and services include paediatricians, a psychologist, a psychiatrist, a mental health counsellor, a respiratory therapist, and an optometry clinic. In addition to in-clinic consultations, this team also facilitates case conferences, school-team consultations, multidisciplinary team meetings, through liaising with other service sectors and outreach services.

between service providers, but must also include improving pathways, networks and information-sharing among providers.

Even in cases where a young person is already connected to outpatient mental health and/or addictions supports, service providers are not always informed when their client attends an emergency room in a crisis unless the patient has expressly consented to the sharing of information, and are often not advised in a timely manner when a youth has been admitted to/discharged from an inpatient unit. This "presents a lot of challenges to team-based care and for the flow in quality of care across the health continuum."


The recent implementation of the electronic Mental Health and Addictions Information System (MHAIS) has been of benefit to community services sharing information amongst each other, and in reducing barriers to the flow of information. Moving forward with getting youth inpatient facilities on this system would further enhance these benefits. Stakeholders also suggested the youth's record be accessible to all service providers in the health system, rather than be limited to mental health and addictions. In this way, it could be accessed by physicians, crisis teams and anyone supporting children and youth. Other stakeholders suggested that all mental health and addictions services, whether provided by schools, community-based organizations or the health system, should be connected.

Health staff also indicated that regular meetings and communication improvements between service providers in different areas such as community and inpatient will assist in better understanding of the strengths and gaps in service provision in different regions throughout the province.

4.5.2 Insufficient Information-Sharing and Coordination of Services Among Child-Serving Systems

Jurisdictional conflicts and poor communication between the different levels of government (i.e., provincial/federal) and between different ministries of the provincial government were cited by stakeholders as a major barrier – impeding coordination of health services and the sharing of information between health providers for the benefit of young people.

This issue is also evident in northern communities where challenges exist between mental health and addictions staff working within different mandates due to working within both federal and municipal lands. There may also be service providers funded by education, a provincial health authority and Health Canada all working in the same community which was reported to cause barriers to continuity of care related to the sharing of information.



When it comes to information sharing, educators reported not being given sufficient information or strategies to support students during the hours spent in school. However, in some communities where this was reported, there was a marked difference in perceptions of mental health and addictions staff, who felt there was a good relationship with schools and regular support.

Health staff and parents/caregivers indicated that crucial pieces of information held by schools often seemed to be missing when trying to coordinate service for a young person.

“[T]eachers are the most uninformed profession that need to be the most informed. [...] We’re the most hands on with our kids every single day and [...] I guarantee – they’re seeing more than parents are seeing.”

- Education

“There is also [...] a disconnect between counsellors in schools and the child and youth counsellors you have. They are not linked up at all. And even us. Because I have had a situation where I have had to link up with the school because some of the kids come to us here. They have been seeing a counsellor for the past four years in school and they come see us and there is no record. We don’t know anything about it. They were seeing a counsellor, but for what?”

- Psychiatrist

“[W]hen your child is in a situation where he’s seeing counsellors and things at school, that kind of information should be shared so that a parent can go through and see a doctor or a counsellor on their own or make some choices as a parent to help your child. I just didn’t know enough.”

- Parent/caregiver

This same issue was also reported in child welfare and justice services. Group home operators reported often receiving insufficient information from the Ministry of Social Services regarding the mental health needs of youth being placed in their home, such as if the child or youth is on medication.

Mental health and addictions workers stated that disruptions in treatment often result from not being informed by the Ministry of Social Services when a child in care has moved. Child protection and justice staff expressed similar concerns of not being informed when a youth disengages or loses contact with mental health or addictions services. As a result, the file may be closed if the youth is lost to the system. If proper communication had occurred, then an opportunity to coordinate and keep the young person engaged is protected.

“Are we working on the same plan together? Is the kid just getting confused, [wondering] ‘Who do I listen to?’”

- Corrections


These disconnects demonstrate that without clear, effective and ongoing communication between sectors, children will continue to fall through the cracks, compromising critical intervention required to address their needs in a holistic and comprehensive manner. While everyone supporting a child or youth likely needs more information, many service providers are hesitant to share too much due to fear of repercussion for doing the wrong thing under *The Health Information Protection Act* (HIPA).

“HIPA has really constricted all of us ‘cause everybody’s too scared to talk and that’s, again, also not doing families or our kiddos any justice at all when nobody can talk to each other.”

- Education

The Story of Waylon

Numerous services providers from the Ministries of Education, Health and Social Services were involved with Waylon over a two-year period. While there was evidence of communication and collaboration among and within these systems, services were not fully integrated - with Waylon and his parents - to identify the source of Waylon’s problems, and identify the interventions needed to help improve his mental health.



While information sharing is critical for intervention and planning, the Advocate recognizes that the decision to share information should not be made lightly. The need to integrate services and share information in the best interests of youth must be balanced with the right to privacy and respect for the wishes of children and youth. Youth stated the issue of confidentiality within mental health and addictions services is important to them – especially when it comes to sharing information with personal contacts, such as family, who may be a trigger for their mental health or addictions challenges in the first place.

Nevertheless, it is important for service providers to note that HIPA contemplates the balancing of other rights, such as the right to the highest attainable standard of health (Article 24) and the right to life, survival and development (Article 6), by allowing the sharing of information when it is in the best interests and for the protection of the child. Section 27(4) of HIPA permits the disclosure of personal health information without the explicit consent of an individual when there are reasonable grounds to believe that “the disclosure will avoid or minimize a danger to the health or safety of any person.” Section 27(2)(b) allows for this disclosure “for the purpose of arranging, assessing the need for, providing, continuing or supporting the provision of a service requested or required by the subject individual”.

What this means is that all sectors need more clarity around what information can and should be shared to protect the well-being of children and youth, while still respecting their privacy and agency. Decisions around information-sharing should come from a place of knowledge, rather than a place of fear. Often, this can be easily determined by talking with the young person and involving them in these decisions. When it is not feasible or timely to secure the consent of the youth, a child rights lens must be applied when sharing information to ensure a balance of these rights.

“It’s time for a change. [...] We’re coming together in crisis, why wouldn’t we come together every day?”

- Community partner

Formal conferences under the *Youth Criminal Justice Act* are a form of collaboration that, if done well and inclusive of sharing information, could enhance coordination of services to youth. However, reports of infrequent case conferences for youth upon discharge from inpatient mental health or addictions treatment are prevalent, and judges in the provincial court system stated these conferences are rarely used due to everyone in the system being so overloaded. The justices reported that even though some dedicated corrections staff seek out this information informally, often no one has the complete picture of what to do.

Stakeholders in every sector agreed that stronger collaboration between them is needed to support the holistic well-being and development of children and youth. This “team approach” must be sustainable, applied systematically and be supported by policy, rather than occur on an ad hoc basis.

“Most [youth] would prefer that we talked to each other, ‘cause they get really tired of retelling their story. And they tend to kind of leave stuff out the more places that they’ve been to.”

- Community Organization



"HUB is a provincial model designed to address acute elevated risk for people and/or families within our community. It provides immediate, coordinated, and integrated responses through mobilization of resources to address situations facing individuals and/or families with acutely elevated risk factors, as recognized across a range of service providers. Information is shared across sector and ultimately, HUB connects people to supports that they may not be aware of or know how to access on their own."

(Retrieved from: <https://saskatoonpolice.ca/hub/>)

"[T]he whole issue of mental health cannot rest solely and unilaterally, on the doorsteps of the health sector either and so, I would say that there needs to be a lot more 'one team' approach in trying to solve this."

- Child welfare

This call for improved information sharing is consistent with **MHAAP Recommendation 11.4 to "[e]nable information sharing within and between all of the service sectors dealing with mental health and addictions and align relevant policies."** In the wake of the release of the **Mental Health and Addictions Action Plan**, stakeholders expected fulsome discussions between the different levels of government responsible for services to Indigenous youth around creating a more seamless way to "work effectively in the same yard". While there may be high-level discussions occurring, participants on the frontline reported there are still high levels of distrust, tension and discord that make this a challenge.

Considering the continued necessity and urgency for this collaboration – as expressed by participants in this project years after the MHAAP was released – it is incumbent on all sectors to coordinate mental health services in a streamlined and barrier-free way. The Government of Saskatchewan's Pillars of Life Suicide Prevention Plan references the importance of collaboration and continuity – it is of the utmost urgency that the government take immediate steps to implement this recommendation across the province.

[T]he kids that I see being most successful are supported all the way around parents and really open communication with everybody that is involved. That is helpful in terms of day-to-day counselling as well as assessments."

- Mental Health

4.5.3 Collaboration with Youth

Young people have the right to participate in matters that affect them and to have their ideas, perspectives and recommendations taken seriously by decision-makers.

Stakeholders across sectors are already aware of this responsibility and in many cases, children and youth are involved in planning. However, as has been highlighted throughout this report, there are many instances where this is not the case, and more effort is required to ensure the perspective of young people is at the fore.

"[W]e need to really listen to the children and what they need because they're the ones that are going through it. And, ultimately, it's their life. [...] [L]ike, we're their support."

- Parent/Caregiver

"No one section works in isolation from the other. The more support that can be provided in one area, will transfer to supporting of the others."

- Education

"I think a lot of teams are trying to do that planning without the youth. [...] But when you have a youth that has the cognitive capacity to be part of that team, they have to be part of that team. They have to be engaged in that process. It's not that they lead that team and make the decisions, but they have to be part of that team."

- Child welfare

Pillars of Life: The Saskatchewan Suicide Prevention Plan

"All sectors need to address suicide prevention within their mandates. Accountability, across and within other ministries, is necessary to ensure suicide prevention is made a priority and remains a priority."

(Retrieved from: <https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/saskatchewan-health-initiatives/suicide-prevention-plan>)

The need for youth collaboration goes beyond just involving young people in the development of their individual care plans. It is of equal importance to include them in the design and planning of service provision at a systemic level. This is already being done in some instances, such as having young people submit their feedback on services via PCOMS (Partners for Change Outcomes Management System)⁸⁹ and Patient and Family Advisory Councils.

However, as recognized by leadership within the mental health and addictions system, more can be done to fully realize the participation rights of children and youth and include their voice in a broader way. This could include consulting young people on the design of physical spaces and programming models and creating community youth councils to inform leadership about the needs of young people specific to their area. The Ministries of Education and Social Services have developed youth councils to inform their work, something the health system ought to consider for better outcomes.

"I think that, wherever we can, we need to – as a standard – use the voice of children and youth and it will guide us. And I think some of the biggest successes we've had, [is when] we've had feedback from the users."

- Mental Health Official

UNCRC Article 12(1)

States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

It is vitally important to give young people the opportunity to express their views – as is their right – and for decision-makers to be accountable by taking their perspectives into serious consideration. Young people want to know that their voice is going to make a difference.

"Sure, we can talk about it right now, but how long is it going to take till someone actually hears the word that's up in the 'big cheese chairs'. That's the thing, right?"

- Youth

"I think that there's a lot of opportunity for youth to have a much greater voice in terms of the design of services, provision of services, and changes to service that, I would say largely doesn't exist right now."

-Mental Health and Addictions Official

⁸⁹ PCOMS is a system designed to solicit client feedback on services, intended to: identify clients at risk for negative outcome before dropout or treatment failure; provide objective, quantifiable data on the effectiveness of providers and systems of care; use measures that are reliable and valid, but feasible for each clinical encounter; and provide a mechanism for consumer preferences to guide choice of intervention. (<https://betteroutcomesnow.com/about-pcoms/>)

4.6 Need for Increased Knowledge, Tools, and Capacity

Although more people are talking about mental health and, to some extent, addictions, youth report still being insufficiently informed. Young people and stakeholders stated this information would be best learned in school, as what is learned through social media or online is not always accurate. There have been recent efforts by both the health and education systems to increase knowledge around mental health and addictions in the classroom.

Curriculum around mental health has been developed and some schools have adopted approaches related to mindfulness and self-regulation, and/or brought in programs such as the Friends program⁹⁰ referenced earlier and Mind Up⁹¹. In some instances, staff from either the health authority or community organizations have been brought in to deliver presentations to students. Additionally, the Saskatchewan Health Authority, along with the Ministries of Education and Health, have jointly piloted the Mental Health Capacity Building program in five schools across Saskatchewan. All these initiatives were identified by stakeholders as positive.

The Advocate is encouraged by the upward movement on these efforts and with the Mental Health Capacity Building pilot. We acknowledge there are schools that have a heavy focus on mental health material and knowledge building in schools, however, implementation of these efforts or initiatives is not consistent across the province.

Mental Health Capacity Building

The Mental Health Capacity Building (MHCB) program promotes a school culture that is supportive of mental health by raising awareness around mental health issues, coping strategies and healthy relationships. MHCB staff engage with students, parents, teachers, and community to provide informational resources, support early interventions, and facilitate access to treatment for children, youth, and families that are experiencing or are at risk of experiencing mental health and addictions related issues.

4.6.1 Children and Youth

On this, youth participants described wanting more information on healthy coping mechanisms to manage their emotions and experiences – especially for use in those times where there is no access to professional support. Youth also stated that, because young people are turning to each other in times of need more often than adults, more knowledge about how to support their peers who are experiencing mental health and addictions challenges would be valuable.

"[U]ntil I took a suicide prevention course, I didn't know, like, the signs and the symptoms. 'Cause I didn't fully understand my own struggles myself either until I took that."

- Youth

"[It is helpful] when they're walking us through, like, how to control your breathing, and how to cope. Give us words on how to cope with it when you have no one to go to."

- Youth

⁹⁰ <https://friendsresilience.org/>

⁹¹ <https://mindup.org/>

"I feel like the stigmas that comes with mental health whenever it comes to a topic in a classroom, everyone gets uncomfortable because they know it's such a tough topic. So maybe if we focus on the positives like healthy coping methods, how to deal if someone comes to you with their mental health, or even if you're not dealing with a mental health issue, how can you relate to a person who is going through that. I feel like focusing on those topics in the classroom will open up conversation and make the individual feel like they are accepted, they are seen equally despite what they might be going through."

- Youth

The Story of Jess

Jess wishes there was a class on mental health in her school so that youth would know more about it, be more understanding, and be more knowledgeable about how to meet their own needs.

Youth suggested that education on mental health and addictions in school needs to begin much earlier than it is currently being offered, and that it should be woven throughout the curriculum rather than be presented as a "one-off" or an elective class. Their suggestions were echoed by stakeholders in both education and health.

"[T]his is outside the realm of health, but [...] I think if we can give our kids some skills, some basic skills in the Kindergarten, Grade 1, 2, 3, we maybe wouldn't see such a huge amount of anxiety in kids. [...] And then maybe they can learn to manage and identify and, you know, wouldn't come to crisis levels."

- Health

"It's mandated to take a Phys ed. course to graduate high school. But mental health is just as important, or maybe even more important, [...] so make that mandatory in the curriculum for our students to learn the content of that before they can graduate, because they need that. [...] It's mandated for physical health. Why not mental health?"

- Education



"The reason my son made it is because we made sure he understood himself. [...] We made sure at a very young age he learned that he had to deal with these issues. [...] These issues are not going to disappear. He's going to run into them. [...] It is important to teach kids how to deal with their issues early. [...] These are the teachings that our kids are missing because parents never got that. These parents were abused, they went to residential school. A lot of them were raised in the child welfare system."

- Elder Advisory Council

The pleas for increased and earlier education around mental health and addictions made by youth participants echoed those of the youth that participated in our *Shhh...LISTEN!!* report. The fact that young people are still asking for this even after improvements have been made indicates that more attention towards building mental health capacity among students of all ages may be required.

"Most of the time, parents don't even get what you're going through."

- Youth

"I think it should be mandatory for foster parents and all caregivers to take a mental health or addictions course before becoming a parent."

- Youth

4.6.2 Parents/Caregivers

"To help the kids, we help the parents".

- Education

Stakeholders across all groups agreed with the youth that parents and caregivers need more education on how to better support their children through their challenges with mental health and addictions.

Many young people described feeling unsupported by their parents/caregivers in their struggles with mental health and addictions and their attempts to seek treatment. Various professionals also expressed concern that some parents/caregivers can be disconnected from the experiences of their children, put "blindness" on due to the stigma continuing to surround these issues, or fail to prioritize following up with services. However, participants also acknowledged that some families face multiple barriers, and engagement with mental health or addictions services for their children (or themselves) can just feel like one more thing that is uncomfortable and scary.

There are also many parents/caregivers trying their very best to support their children and describe not feeling confident in having the knowledge or skills and lacking the tools to manage their child's illness or to keep their child safe. Stakeholders identified the need for increased access to:



- information on various diagnoses, what to expect with each and how to effectively communicate with their children to avoid triggers;
- facilitated parent/caregiver support groups that combine educational elements with a supportive community in which to share their experiences and learn from each other; and,
- broader parenting classes – not restricted to themes around mental health and addictions – that can help parents/caregivers support their children to live generally healthier lifestyles.

The Saskatchewan Health Authority does provide these services, but only in some communities. Stakeholders emphasized that, for these initiatives to be successful, transportation and food must be provided at no cost to ensure there are no barriers for parents/caregivers to get help.

As recognized in the UNCRC ⁹², families are the "fundamental group of society and the natural environment for the growth and well-being" of children. As such, "States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities". To fulfil these responsibilities, parents and caregivers must be supported to support their children.

4.6.3 Teachers

Children and youth spend more time in school than at home. Teachers and school staff hold a significant role in the lives of young people and are well-positioned to identify issues when they arise. However, both young people and stakeholders in education collectively agreed that teachers are often not adequately equipped to recognize the signs a student may be struggling with mental health or addictions, or to effectively respond to the confidential and sensitive information shared with them by students.

There are efforts being made to increase the knowledge capacity of education staff, such as training in Mental Health First Aid, and the delivery of information on professional development days. Additionally, among the five schools where the **Mental Health Capacity Building** program is being piloted, evaluations noted a significant increase in staff confidence when interacting with students about their mental health.⁹³ However, education staff stated mental health training remains limited and more intensive training is only available to those who seek it out.

MHAAP System Goal: Focus on Prevention & Early Intervention

8. Build on existing programs that recognize the importance of healthy families and communities and positive environments for emotional development. [...]

8.3. Improve the accessibility and coordination of supports for parents and families, including parenting skills building and respite. Broad-based education on good beginnings for children, parenting education, and enhanced intensive supports for parents and children with higher needs will enhance early childhood development. Existing provincial parenting resources should be better coordinated to provide a more accessible continuum of support.

"I know the university isn't talking about trauma-informed practice, but yet so many people are starting their careers in community schools, and they just don't have the skillset [for] understanding 'How do we work with our most vulnerable youth?'"

- Education

⁹² UNCRC Preamble and Article 18

⁹³ Saskatchewan Health Authority. (2020). Mental Health Capacity Building Evaluation Report June 2020. (Retrieved from: <https://www.saskhealthauthority.ca/sites/default/files/2021-10/Mental-Health-Capacity-Building-Evaluation-Report-June-2020.pdf>)

"I think moving to one health authority perhaps we could establish some sort of standardized training for everybody to take when they come in and take positions. Because I've also worked different health regions and I can see too that working in [one] Health Region and then coming here [...] I've had way more training in this Health Region than I ever did in [the other]."

- Mental Health Counsellor

Stakeholders in education wanted to see university classes for teachers on mental health and addictions, mental health first aid and suicide prevention/ intervention training provided to all school staff, in addition to more strategies for supporting children and youth with anxiety or other conditions in the classroom.

While teachers should not be expected to also function as mental health and addictions counsellors, there was consensus among participants that educators need the tools to recognize when a student requires a referral to formal supports.

4.6.4 Health-Care Providers

Both practitioners and officials within the mental health and addictions system indicated there are gaps in clinician training and knowledge of trends that impact their ability to provide service.

Those we spoke to in health leadership expressed concerns about the limited instruction around mental health and addictions provided to university social work students, thereby requiring new recruits to be trained 'on the job'. Health staff advised that on-the-job training can be inconsistent across the province and should be standardized, like the core training provided to staff in other government ministries, such as child welfare and corrections.

Clinicians in different areas of the province identified a need for more training in assessing and responding to youth with suicide ideation, and youth struggling with issues related to sexual orientation and gender identity. Clinicians also expressed wanting to build their toolbox of skills around a variety of therapy techniques in addition to the standard approach of Cognitive Behavioural Therapy to better tailor their services to the needs of the youth but said there are few opportunities for training.

Mental health professionals and other stakeholders also indicated primary care physicians required access to more training, to have more tools at their disposal in addition to prescribing medication or sending a youth to the emergency room. The CanREACH program referenced earlier has the potential to help close this gap in physician knowledge. However, stakeholders identified the need to build knowledge capacity for students in medical school and to allocate more training time for mental health and addictions issues in proportion with their prevalence among the population.

"We've identified a gap of physician capacity and comfort with mental health and addictions presentations. [...] [T]here's lots of doctors who either haven't had training or don't want to have training. It's a huge gap."

- Mental Health Official

Health providers at the management level also identified the need for better data on youth drug and alcohol consumption, the impact of the legalization of cannabis, eating disorders, self-harm, suicide, misuse of video games and social media to better inform the training provided, and to inform policymakers in service decisions.

Other professionals such as custody staff, judges, group home operators and police also conveyed being ill-equipped to support young people with ongoing mental health and addictions challenges beyond basic mental health first aid and de-escalation techniques.

The fact that stakeholders across the spectrum of child-serving systems acknowledge a need for increased knowledge and tools to better support youth with mental health and addictions within their services is further evidence of the importance of approaching these issues in a holistic and coordinated way.

"Community needs to see that mental health is not just a health or education issue. This drives me nuts. Because it's mental health, they think it's a health issue. And because it is expressed in school, they think it's a school issue. [...] Wellness will never happen if we think it's just health or education. It demands a community response."

- Community Organization

4.7 Supporting Youth Transitioning from Youth to Adult Mental Health and Addictions Services

The transition from youth to adulthood is a tumultuous time fraught with change.⁹⁴ This period can be very stressful for young people, generally, and can be even more complicated for those struggling with mental health or addiction-related challenges. Systems in Saskatchewan typically define this transition as occurring upon a young person's 18th birthday. The policies and practices governing service provision across sectors are often divided between those offered to "children and youth" and to "adults".

For those young people fortunate enough to have access to consistent mental health and/or addictions supports as a child, there is an extremely high risk of losing those supports once the young person becomes an adult by legal age. Although there are some mental health services without strict age cutoffs, such as instances in which child psychiatrists continue to follow patients with significant needs until they can be connected to an adult psychiatrist, we heard from parents/families who described frustration at having to start all over again in their quest to access appropriate services once their child is cut off from youth services and told to access the adult system. Others described feelings of dread and uncertainty about the future due to not being sufficiently informed of what will happen when their child turns 18.

94. Doucette, M. (2020). A Long Road Paved With Solutions: 'Aging out' of care reports in Canada – Key recommendations and timelines (1987 – 2020). National Council of Youth in Care Advocates. (Retrieved from: https://f54667c7-b33a-4709-8c6a-66716a068b2d.usrfiles.com/ugd/f54667_30baf6f5b4eb4a8194c47ab10ec17ad7.pdf)

"I went there [Child and Youth Mental Health and Addictions Services] when I was under 18 and saw a counsellor there for years. And she was wonderful, and she really helped me get out of a situation where otherwise I may not have made it out alive. Being very frank and somewhat dark. [...] The second you turn 18, [Adult] Mental Health and Addictions Services counselling does not offer an ongoing counsellor who you can see over a longer period of time. They offer a goal-based counsellor for a maximum amount of four appointments. That's it. Once those four appointments are over. You're out. You got to start through the system and find another counsellor in that system. Start over. There is no ongoing support there that's available outside of private practice which is incredibly expensive and inaccessible."

- Youth Advisory Council

"When we went there at 16, [the psychiatrist] said, 'Well, I will see them. They're almost out of my age range, but I will see them until they are 18.' [...] We were lucky enough to access a child psychiatrist. But we need to have...what would be really great is if we had one that was like a bridge. My child was 16, so they didn't see them for very long and now they're 19. [...] They can't be seen by that doctor anymore, and now we have to start all over again with the waiting lists and the referral and the whole bit."

- Parent/Caregiver

"She's 18 now. So that piece of the puzzle is now still a question mark. I don't know what that's going to turn out to be. Are they going to transfer her because of her history? Is it going to be a closed door and now we have to start the whole process for adult? I have no idea."

- Parent/Caregiver

Mental health staff share these concerns and express concerns with delays caused by an inability to submit a referral to an adult psychiatrist until a young person has turned 18.

"So, they get on a list for child psychiatry, and they have that magic 18th birthday, and that referral has to start back at the beginning [...]. The doctor has to resend one to an adult psychiatrist and start that process over again."

- Mental Health and Addictions

Knowing that a young person will likely be on the waitlist for a child psychiatrist until long after their 18th birthday, these professionals called for the ability to make a referral to an adult psychiatrist prior to this date to avoid additional delays and work toward a seamless transition.

When youth are under 18, their engagement with treatment can be supported by the adults in their lives. Upon reaching the age of majority, individuals have much more autonomy over their care and level of engagement. This is described as distressing by several parents/caregivers, educators and health care providers supporting young people whose success was jeopardized when left to their own devices. This was described as particularly problematic for youth with complex needs who, largely due to their mental health or addictions challenges, may choose to discontinue service after the age of 18, or do not have the maturity to consistently manage their treatment. For young adults facing the myriad of other challenges related to this

"What happens when they turn 18? [...] They are not ready to be an adult. They need help walking through all of that. But the system writes them off and says they have the full responsibility to be an adult."

- Elder Advisory Council

"That's something that should be changed. Because you're still in the processing stage of your life – 'cause now they're going into the most stressful parts of their life."

- Youth

transition period, such as aging out of care, finding affordable housing, and paying bills, going to the psychiatrist may be the "last thing on [their] mind".

"I still have to remind her about these appointments, and it's like they [the health system] think once they hit that magical 18 that they can just do all this stuff on their own. And, as a parent, if your child is laying on that bed on machines, you think they're in the state of mind to say who they can talk to? Like, I'm here fighting for her to be alive, and they won't talk to me because she is an adult."

- Parent/Caregiver

"Follow-up after a kid's graduated is a huge, huge component at this school. We've seen kids who are schizophrenic, and the only reason they can stay stable is because we're making sure that they're given a shot, or they're getting to see that person when they need to see it. And so, that does give them success. But then they graduate and, all of a sudden, it's like they're out of our hands. [...] But there isn't really anything in place for that aftercare that so many of our kids need with mental health and with addictions. We've seen kids who will totally clean themselves up while they're here, because they want to graduate. [...] And then we hear, like, you know, a year later that kid committed suicide, that kid overdosed. [...] We knew they had issues and we helped them through those issues when they were here. But then, you know, once they were gone, we go to a funeral a year later, two years later."

- Education

"As soon as they walked out of our building, there was no one there to help them make those good choices."

- Education

"One of the things that I sometimes feel ill-equipped to deal with is cognitively challenged youth that are dealing with addictions. [...] I just sometimes feel addictions can be so abstract. And we have seen where they age out and it's horrific what happens – because they end up in the justice system, they end up, you know, with a lot of multiple issues, right? And we see the train derailing well before it derails. We all knew what was happening, but it was like – you know – it was kind of like nobody's job and nobody really knew how to manage."

- Addictions Counsellor

This issue was also identified in the **2014 Mental Health and Addictions Action Plan** which called for improved transitions within and across services, and specifically for youth transitioning from the youth to adult mental health system. The MHAAP acknowledged both the gap in services for young adults and the unsuitability of adult services for older youth who “may lack the required independence, initiative in seeking out their own supports or feel uncomfortable with older peers.”⁹⁵ Clearly, there is still a long way to go in meeting the needs of these young people.

“If they had somebody that was for young adults, because [...] it seems like kids that are 10 to 13 may have different issues than kids from 16 to 20.”

- Parent/Caregiver

As with many barriers outlined in this report, officials within the health system are aware of this gap and acknowledge that more must be done to address it:

“There’s those kids that were maybe identified later in their adolescence as maybe having a mental health illness or problem or issue that aren’t solidly connected to care. And then they become 18, and they’re adults now and then the model for working with them changes – because Child and Youth Services work lots with parents and with parent consent. All of a sudden, the child is 18, right? And that is a real vulnerability if they’re not connected to some sort of program that at least kind of engages them, or motivates them, or keeps an eye on them – so that if they are failing, there’s a safety net for them. [...] Parents are at their wit’s end because they don’t have authority anymore. And some of those kids are really ill, and it takes...and they go down that rabbit hole quite deeply before...usually it’s a police officer or some heavy intervention that then, sort of, finds them and picks them up [...]. If we could avoid that, I think that would do wonders.”

- Mental Health and Addictions Official

Some participants suggested increasing the age limit for Child and Youth Services to align with evidence⁹⁶ that the brain continues to develop into the late twenties.

One health professional we spoke with stated it as a positive that rural mental health and addictions counsellors have combined caseloads of youth and adults, as this enables them to continue working with a young person past their 18th birthday. However, this model must also be balanced with the considerable concerns raised about the lack of rural clinicians specialized in serving children and youth. Other stakeholders suggested creating a new team of professionals dedicated to working with older youth and emerging adults.

The Advocate is encouraged by the Ministry of Health's indication that several recent initiatives are being designed to work with an expanded age range, such as the youth Community Recovery Teams and Integrated Youth Services mentioned earlier.

⁹⁵ Stockdale-Winder, F. (2014). Working Together for Change: A 10 Year Mental Health and Addictions Action Plan for Saskatchewan. (Retrieved from: <https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/saskatchewan-health-initiatives/mental-health-and-addictions-action-plan>). pp. 46

⁹⁶ Maurier, R. (2011). “Some brain wiring continues to develop well into our 20s.” Science Daily. Edmonton: University of Alberta Faculty of Medicine & Dentistry. (Retrieved from <https://www.sciencedaily.com/releases/2011/09/110922134617.html>)

4.8 Overall Impacts of Other Systems on Child and Youth Well-Being

There is no question that when it comes to the mental well-being of young people, the systemic issues embedded in each child-serving system have negative impacts on children. While it is imperative that the mental health system adopt a better coordinated and integrated service model within and across systems, the other issues and impacts within child-serving systems are noted by stakeholders as contributing stand-alone factors to compromising the mental well-being of children.

Education plays a significant role in their development. Therefore, what occurs between those walls contributes to the shaping of their identity and overall wellness. When children and youth become involved in either the child protection or justice systems, there is considerable instability – and often trauma – in their lives. The adverse experiences young people face in these circumstances put them at greater risk of mental health problems and addictions. It is well known that the mere involvement of young people in these systems elevates their risk significantly.^{97 98} Indigenous children disproportionately carry these burdens due to their overrepresentation in both these systems, generally.

4.8.1 Education

Under Article 29 of the UNCRC, the aim of education is, in part, to develop “the child's personality, talents and mental and physical abilities to their fullest potential”. This includes strengthening their capacity to enjoy the full range of their human rights and “developing their human dignity, self-esteem and confidence”.⁹⁹ As such, the education system has an obligation to place as high a priority on mental fitness as on intellectual ability.

However, youth participants reported that school can be a source of stress and, if not properly supported, this environment can add to the complex issues often faced in other areas of their life.

“When you have a school with 600 students, you’re not going to be able to take everyone to the side and be like, ‘Are you okay? I noticed you’re not doing too good today,’ or ‘Your work’s not looking how it should be?’”

- Youth

⁹⁷ Health Canada. (2013). National Aboriginal Youth Suicide Prevention Strategy (NAYSPS): Program Framework. Ottawa: Government of Canada. (Retrieved from: https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniash-spnia/alt_formats/pdf/pubs/promotion/_suicide/strat-prev-youth-jeunes-eng.pdf)

⁹⁸ Office of the Children's Advocate Manitoba. (2015). The Changing Face of Youth Suicide in Manitoba and the Narrow Window for Intervention: Phase One Report. Winnipeg: Author (Retrieved from: http://childrensadvocate.mb.ca/wp-content/uploads/The-Changing-Face-of-Youth-Suicide-in-Manitoba_FINAL_web.pdf)

⁹⁹ UN Committee on the Rights of the Child. (2001). General Comment No. 1: The Aims of Education (2001). CRC/GC/2001/1, Geneva, CH: Author. para. 2



"And it even goes down into the classrooms – how teachers talk to kids way down in the lower elementary grades. If a teacher doesn't pay proper attention and make that child feel welcome in the school, that child is going to – as he progresses through that system – he is not going to bond with the school system and succeed at what's being asked of him or her. [...] And then if you come from a home that really pushes education, that increases the anxiety in one direction. If you come from a home that doesn't really care, then it pushes it in another direction. But we got to really work with the educators I think on these issues or else we are going to see more and more of these mental health and addictions issues coming forward."

- Elder Advisory Council

"I feel like when kids get stressed, it gets really bad because school is really stressful at times. [...] They may be feeling overwhelmed with how much work you have to do, how much studying, your grades and passing."

- Youth

Youth described positive relationships with teachers as an important factor in their well-being. Yet, the capacity of school staff to connect with students, recognize issues as they arise, and implement strategies to address them is limited. These circumstances were most widely attributed to large class sizes and insufficient classroom support. Stakeholders in the North reported high staff turnover made it difficult for them to get to know students well enough to identify issues.

As hard as educators try, without additional supports, teachers do not have the time to provide all students with the nurturing required to manage the various issues children carry with them to school – nor can teachers work to develop a young person's "human dignity, self-esteem and confidence", at the same time as delivering the required curriculum.

When teachers assist students in crisis, it means leaving the other children without support. These circumstances lead to the same cycle seen in the health system where only those youth with the most acute needs are served while the needs of others go unaddressed, until those children are in crisis too. Case in point, we heard many examples of behavioural plans not being strictly followed and learning disabilities going unnoticed, both of which can have devastating consequences on the academic and emotional success of young people.

Participants emphasized the need for smaller class sizes, and more educational assistants and student mentors, stating these resources would enable all staff to have more time to foster positive relationships and meet student needs.

"The EA's, in a way, were kind of like my counsellors almost. [...] I know having an EA one-on-one was very, very, very successful for me. And she told other teachers about my quirks and personalities."

- Youth

"[Re: student mentors] You just talk to them about anything, and they will help you out [...]. They offer it when your family doesn't want to help, like when you don't want to ask your family. [You feel] supported."

- Youth Focus Group

The importance of allowing time and space for students to process their emotions during the school day was also identified by youth participants as being important. Strategies such as more opportunities for body breaks, self-regulation coping skills in the classroom, physical areas for students to decompress when needing to "chill" or when feeling "unsafe", and free time at the end of the day so students "can go home on a happy note" were identified by young people as being helpful. Indigenous students spoke of the benefits experienced in schools when allowed to smudge.

"Maybe they could, like, give you a break. When you're just like totally not in the mood for school [like sick leave from work]. 'Cause it kind of just keeps going on like, no one's going to wait for you to stop being sad."

- Youth



Some schools have adopted a trauma-informed approach and others acknowledged the need to begin operating in this way. Educators indicated this included the need for increased accessibility to speech-language pathologists and occupational therapists, as these services are also beneficial in easing the impact of anxiety and addressing trauma through sensory work.

"I feel like with this place, it's also a lot about forming bonds and just, like, one on one stuff. [...] It's, like, more personal and that makes it a bit more comfortable, I guess."

- Youth (Trauma-informed school)

Students in schools who experienced significant loss due to suicide of family or peers, or accidents, emphasized the need to have appropriate plans in place to meet the needs of grieving students before such tragedy strikes. Young people want school staff to be more open and communicative with students and should specifically check in on the well-being of those who were close to the students involved.

Other resources that stakeholders, including youth, identified as positively impacting student mental well-being in school and that should have widespread implementation include:

- breakfast, lunch, and snack programs;
- the provision of winter clothing;
- homework assistance;
- daycare centres for student parents;
- Indigenous advocates in every school;
- outdoor activities;
- access to dentistry and medical services at school;
- gender and sexual diversity alliance groups;
- police community outreach officers being engaged in school activities outside of crises;
- school/family liaisons;
- classes to prepare older students for independent living (ex. personal finance and life transitions); and,
- continued support after graduation.

Education is a well-positioned system to help connect the dots to service provision for the well-being of young people who spend most of their time at school. There is a special onus on all child-serving systems to deliver their services in a way that is both culturally and trauma-informed and mitigates any risk to the well-being of the children it serves to the highest extent possible.

4.8.2 Child Welfare

Protection from abuse and neglect is necessary for both the physical and mental well-being of children and youth. In addition, involvement in the child welfare system can, unfortunately, be a quicker path to mental health services. However, any traumas young people have experienced in their homes are compounded by the processes and policies inherent to this system, which often further contribute to mental distress. The main issues identified by participants were:

- lack of understanding by children and youth as to why they are in care;
- loss of family connections;
- removal from their home and everything that is known to them;
- loss of language and culture for Indigenous children;
- absence of mental health support immediately following apprehension;
- disruption caused by multiple placement moves;
- inability to connect with caregivers who are constantly changing or withhold affection;
- caregivers without the skills to support youth with complex needs;
- lack of caregivers in northern Saskatchewan;
- unwillingness of the system to take protective action with youth aged 14 and up;
- lack of meaningful supports to 16 and 17-year-old youth receiving services under section 10 of *The Child and Family Services Act*, and unrealistic requirements for youth with mental health or addictions concerns to attend school or be employed; and,
- youth being unprepared to transition out of care and into independent living.

Young people called for increased in-home support to be provided to families to prevent children from being taken into care and for mental health supports to be provided as soon as a child is removed from their family.

"I was put into foster care. When it did happen, my family was taken away, there was no supports for mental health or anything. We moved, so we knew no one and we had nothing, and there were no supports or help with that at all. No counselling – nothing – was offered. And not knowing anyone or the people around either made it almost impossible to get help. So, I do think removing kids from dangerous situations are very important, but it also a scarring and traumatic experience. And then to offer no support system or help? That is almost irresponsible of the government, especially when youth suicides are so high. I think it's very important that supports are offered in situations like that, so youth don't feel alone."

- Parent/Caregiver
Focus Group

- Youth

"We need an Indigenous advocate at each school. [...] Not every school qualifies and that's what the problem is. [...] They just pick the schools with probably the highest Indigenous enrollment, [...] which is sad because that doesn't mean we don't have kids that need it."

"I'd like to see some kind of mental health screening for children in care – and especially young children in care. I think the younger ones often get kind of forgotten because they sometimes don't show as much destructive behavior. Just like they had their teeth checked or their vision checked."

- Mental Health and Addictions

Participants also indicated the child protection system must be more responsive to the needs of older youth and want to see more action on child protection reports involving youth aged 14 and up and increased extension of eligibility for support under section 56 of *The Child and Family Services Act*. Many group homes do not accept youth over age 16, and social assistance benefits often only cover the cost of rentals in vulnerable neighbourhoods. Overall housing for these youth was identified as a priority area for improvement.

When it is time for youth to become independent – either under sections 10 or 56 – it is imperative that these young people be properly prepared for this transition. Because traumas and substance misuse are often inadequately addressed, or even exacerbated, while in care, these young people may require even more support than other youth. Stakeholders stated that the process of transitioning to independence needed to begin earlier, last longer and be better supported by social workers with available time to spend with youth. Care-experienced youth asked for a mandatory "independence program" that could be flexible based on individual needs, such as those relating to mental health, addictions or teen pregnancy.

Other participant-identified needs included:

- more access to Elders for youth in care;
- training for foster parents and other caregivers in how to support young people with mental health and addictions;
- data plans to be provided on cell phones so youth can better navigate things like public transportation; and,
- increased confidentiality in rural and remote areas when a child protection report is made.

Reconciliation in child welfare was identified by the Advocate's Elder Advisory Council as being paramount in addressing the past and current harms caused by the system. The Elders applauded the efforts of Indigenous people to put an end to the practice of using birth alerts and looked with hope to the implementation of *An Act Respecting First Nations, Inuit and Métis children, youth, and families*. However, the Elders indicated there is more to be done by the provincial government when acting as a responsible parent to Indigenous children – who are gravely over-represented in the child welfare system – to ensure children can learn and grow in their language and culture.

"One of the areas that's problematic, I think it's getting more and more serious, is [...] the aging out kids – I'm seeing a lot of them on the street. These are kids that are aging out who haven't had a relationship with a family. They have nowhere to go, and they are vulnerable, and they end up not having a place but being on the street and then being vulnerable. [...] I think it needs to be looked at. Because we can't miss them. We're losing them. Because these kids will die where they are."

- Elder Advisory
Council



"When I pass from this world, I go into the spirit world. When I go there, [...] I'm going to be known by my spirit name. [...] That's the name that I'll be addressed with. And our kids – we have an obligation as parents to provide them with that. In the absence of parents, that naming should not be ignored. And particularly when the government is a parent or, you know, Social Services is a parent of these kids, there is a spiritual, moral obligation to reach these kids. Because [...] the name that they're given often grounds them and helps them take a path that is a little straighter than the one we walk...you know, the difficult path. It prepares that future for them and in how they behave. And I think it would take them away from some of the temptations [...]."

- Elder Advisory Council

4.8.3 Justice

Research shows that a significant percentage of youth crime is driven by the misuse of drugs or alcohol and/or a need to fund addictions. Untreated mental health can also be a contributing factor.¹⁰⁰ *The Youth Criminal Justice Act* is based upon the principles of rehabilitation and reintegration. Therefore, the justice system can provide an opportunity for young people in conflict with the law to have their mental health and addictions needs identified and addressed.

However, as with the child protection system, how services are currently being delivered can get in the way of a young person's success. Various stakeholders in health and justice indicated that it appears the youth correctional system has drifted from the focus of rehabilitation and reintegration.

"There's a real confusion between helping and punishing, and that's always been a situation with the youth justice system."

- Judge

Several stakeholder groups, including many provincial court judges, identified the need for youth mental health and drug treatment courts like the court available to adults. It was conveyed that these processes would lead to more comprehensive planning and services for youth to assist in addressing their issues and, therefore, aid in their rehabilitation and reintegration. This approach would address a young person's needs, however, it would require an investment of resources and collaboration with other systems, such as Health and the Ministry of Social Services.

"Like, if you're willing to go into some kind of program for yourself so you can work on a case plan. So, if you go to that, you can get your sentence shortened. Because it would be something to look forward to. Gives you a good motive."

- Youth

We also heard that youth sentenced to custody are disadvantaged by the lack of therapeutic support. With limited access to secure detox units and limited nursing hours within youth custody facilities, stakeholders in corrections stated young people are often admitted to custody under the influence of drugs or alcohol and may go through a detox period without the full supervision of medical staff.

Custody staff also reported often having to supervise youth with high mental health needs, as the province does not have a secure medical facility for young people. Even with the mental health and other training provided to correctional workers, it is difficult to establish therapeutic relationships with young people at the same time as being an authority figure. As a result, youth are often taken back and forth to the hospital only to be put on new medication.

UNDRIP Article 22 (1)

Particular attention shall be paid to the rights and special needs of indigenous [...] youth, children, and persons with disabilities in the implementation of this Declaration.

Additionally, when sentenced to custody, youth are often placed far from their home communities and/or frequently moved around to attend court. Having only one secure facility for female youth located in Regina means that these youth are isolated from their families, communities and their mental health supports, which further impacts their mental well-being in a negative way.

Issues identified related to release from a custody facility mirrored the issues related to discharge from a psychiatric unit or addictions inpatient treatment. Although there are transitional resources in some cities that connect youth with education and employment, these are not available to youth in many communities across the province. As a result,

- youth often have nowhere to go, or return to environments that continue to increase their risks for criminal behaviour;
- youth lack of connection to supports negatively impacts a young person's mental health issues and substance misuse; and,
- the youth's overall risk is increased without proper reintegration and available mental health and addictions supports prior to release.

As with the child welfare system, Indigenous youth are disproportionately represented in the criminal justice system. As such, special priority - through the framework of reconciliation - must be placed on meeting their holistic needs while in custody and prior to release, as is their right under Article 22 of the UNDRIP and their rights under the UNCRC.

"It's much more effective in youth court if we can develop a plan and actually see the plan being implemented prior to sentencing."

- Judge



¹⁰⁰ Public Safety Canada. (2017). RESEARCH HIGHLIGHTS Crime Prevention Youth Mental Health, Mental Illness & Crime. Government of Canada. 2017-H01-CP (Retrieved from: <https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/2017-h01-cp/2017-h01-cp-en.pdf>)

5.0

Recommendations

Our intention with this work was to examine the current context of mental health and addictions services to children and youth since the release of the Mental Health and Addictions Plan using a child rights lens. Our findings indicate that many of the issues identified by the MHAAP remain. While there are some unique recommendations arising from our findings, our hope is that this increased focus on the interests and voices of children and youth will help decision-makers to see the impact these persistent barriers continue to have on the lives of young people.

While we know COVID-19 has created obstacles to advancing the MHAAP recommendations, it has also increased the urgency with which these recommendations must be implemented, and the reasons why all systems involved must continue to make child and youth well-being a priority.

Children and youth in Saskatchewan are facing an under-resourced mental health and addictions system that must concentrate its efforts on responding to crisis, rather than on prevention and early intervention. The simplistic solution is to recommend more service providers and health facilities to increase the system's capacity to treat children and youth earlier – and we emphasize that this is sorely needed. However, while this issue is reflected to some extent in our recommendations, we have focused on revitalizing and elaborating on recommendations from the MHAAP that will have the biggest impact on the common issues identified by participants in this project. We have also put forward new recommendations in contribution to the existing roadmap by highlighting the government's obligations to focus on the needs, interests, and rights of children.

As a result of this approach, there are not recommendations to address every barrier identified or solution suggested by project participants throughout this report. Nonetheless, participants offered a rich body of content and innovative ideas that can be drawn from to make improvements to services for children. We strongly encourage all child-serving ministries, systems, and providers to consider whether those actions or steps, in addition to our formal recommendations, could be implemented within their practice or area of the province to better serve Saskatchewan's young people.

Recommendation #1

The Ministry of Health and the Health Authorities develop and implement Youth Advisory Councils to incorporate youth perspective in the design of services, programming models and evaluations, and to inform leadership about the needs of young people who obtain these services.

Further to Article 12 of the UNCRC, children and youth have the right to participate and freely express their views in all matters affecting them and to have their views given due weight by decision-makers. This right extends to participation in the planning and evaluation of health care services on a systemic level. Opportunities for youth to exercise this right would be served through the creation of Youth Advisory Councils at all levels of planning and evaluation. The Committee on the Rights of the Child has given the following direction:

"The Advocate applauds these opportunities for youth to have a say in systems that so inherently impact their lives and urges all child-serving systems to make meaningful, sustained youth engagement a core element in all aspects of service design and evaluation."

"States parties should also introduce measures enabling children to contribute their views and experiences to the planning and programming of services for their health and development. Their views should be sought on all aspects of health provision, including what services are needed, how and where they are best provided, discriminatory barriers to accessing services, quality, and attitudes of health professionals, and how to promote children's capacities to take increasing levels of responsibility for their own health and development."¹⁰¹

The views of children and youth should continue to be sought through current methods used by the health system. Youth Advisory Councils at both the Ministry and Health Authority levels would complement this work through more in-depth and ongoing consultation with young people specific to the design and evaluation of mental health and addictions services. We emphasize that engagement with youth must protect the rights and dignity of young people and be grounded in the principles for youth engagement identified by the *Committee on the Rights of the Child in its General comment No. 12 (2009): The right of the child to be heard*.¹⁰²

In creating Youth Advisory Councils, the Ministry of Health and the Health Authorities would align with other public child-serving systems in Saskatchewan that have taken this important and necessary step.

The Ministry of Education has developed a Youth Council composed of diverse individuals from school divisions across the province whose role is "to provide advice and insights on education policies, curriculum, programs and priorities."¹⁰³ The Ministry of Social Services has developed a Youth Engagement Strategy which includes the creation, in partnership with community organizations, of three Youth Advisory Teams that provide guidance on the supports and services important to them. The Advocate applauds these opportunities for youth to have a say in systems that so inherently impact their lives and urges all child-serving systems to make meaningful, sustained youth engagement a core element in all aspects of service design and evaluation.

Recommendation #2

The Ministry of Health and the Saskatchewan Health Authority satisfy, without further delay, the Mental Health and Addictions Action Plan "Recommendation #2" which states:

"Decrease wait times for mental health and addictions treatments, services and supports to meet or exceed public expectations, with early focus on counselling and psychiatry supports for children and youth."

The 2014 Mental Health and Addictions Plan found that timely access to services was the top priority at that time. Our findings validate this as well. **This MHAAP recommendation is for wait times to "meet or exceed public expectations."** With a reported 800 or so children and youth on the waitlist for psychiatry services in Saskatoon alone, this is far from being met.

¹⁰¹ UN Committee on the Rights of the Child. (2009). General comment No. 12 (2009): The right of the child to be heard, CRC/C/GC/12. Geneva, CH: United Nations (Retrieved from: <https://www.refworld.org/docid/4ae562c52.html>)

¹⁰² Ibid. pp. 29-31

¹⁰³ Ministry of Education: <https://www.saskatchewan.ca/residents/education-and-learning/provincial-youth-council#:~:text=The%20mandate%20of%20the%202021,delivery%20of%20education%20in%20Saskatchewan.>

"These circumstances must be improved to provide meaningful service to children and youth and to engage in the early intervention that is so obviously required."

When it comes to counselling, even though triage targets were reported to be largely met in rural areas, those timelines do not meet public expectations. Wait times for outpatient counselling were not available from the Ministry of Health for Regina and Saskatoon, however, stakeholders indicated that the counselling needs of children in those cities were not being met. These circumstances must be improved to provide meaningful service to children and youth and to engage in the early intervention that is so obviously required. The 10-year period envisioned by the **Mental Health and Addictions Action Plan** to address the gaps and barriers to service is nearing its end. As the top priority, we emphasize the urgency with which this issue must be addressed, and the responsibility of the government to do all it can to mitigate it.

Recommendation #3

The Ministry of Health, Ministry of Education and the Saskatchewan Health Authority expand the Mental Health Capacity Building initiative across the province.

The rationale for this recommendation is reflected in the theme on Increasing Knowledge, Tools, and Capacity where youth asked for more information on mental health and addictions issues. Young people also wanted their teachers to be more informed. The Mental Health Capacity Building (MHCB) program targets both areas. Based on best practice, the outcome measures from the recent evaluation indicate success in increasing mental health literacy, reducing stigma and encouraging help-seeking behaviours in youth. Furthermore, the capacity and confidence of staff in interacting with students about mental health were enhanced.

Stakeholders across groups believed that education on mental health and addictions needed to take place earlier. The provincial pilot sites are predominantly high schools. Any expansion of the MHCB initiative should endeavour to include elementary schools. This would facilitate inroads on the issue of early intervention and prevention raised in this report. MHCB recognizes the importance of early intervention given mental health problems can and do occur in young children. In addition, the need for MHCB is linked to the theme on Navigating Mental Health Services as it helps youth, families and school staff make connections to services in the community.

Recommendation #4

The Ministry of Health, Ministry of Education, the Health Authorities and school divisions work jointly to fund and implement a greater presence of mental health counsellors and Indigenous Elders/Knowledge Keepers in schools.

Our findings indicate there is a need for *both* the universal mental health promotion of the MHCB initiative *and* adequate access to individual mental health counselling in elementary and high school environments. However, there are not enough school-based mental health counsellors to meet the needs of youth. Ensuring adequate access to these supports in school would be consistent with the government's efforts to implement a stepped care approach where **"individuals are matched to the care they need, in the most appropriate setting."**¹⁰⁴

It was overwhelmingly clear from our discussions with young people that the services of school-based mental health counsellors and Indigenous Elders/Knowledge Keepers are effective due to:

- the ease and immediacy of access;
- the comfort of service provision in a familiar setting;
- the providers' familiarity with the student, their family, and their everyday environment; and,
- the ability to develop trusting relationships arising from these factors.

Other stakeholders, including parents/caregivers, educators and health providers agreed that school-based services are necessary for early intervention and the prevention of unmet mental health needs escalating to the point of crisis. These findings are supported by other research and recommendations from across Canada and other jurisdictions showing the benefits of and calling for school-based mental health counselling in elementary and high school.^{105 106 107 108} If sufficiently available, these services would better protect the rights of children to positive mental well-being as well as reduce pressures on more formal and costly mental health therapies. School-based services can support students experiencing episodes of mental distress, address issues impacting their learning in real-time and assist those youth who are receiving clinical services with the practical application of any strategies they are given.

The MHCB initiative has been a positive step toward implementing the recommendations of the **Mental Health and Addictions Action Plan** to promote better emotional health for children and increase awareness of mental health issues in children and school staff. However, Recommendation 9.1 to **"[i]ncrease the availability of mental health and addictions clinicians for school-aged children"** within schools has not seen similar progress.

All child-serving systems tasked with protecting the health and education of children and youth have a role in ensuring these supports are sufficiently available, accessible, and provided by adequately trained practitioners. The provision of these resources will require additional investment by government as a whole and must not be achieved by taking support away from children in other areas crucial to their learning.

Recommendation #5

The Ministry of Health and the Saskatchewan Health Authority expand outreach-based mental health and addictions services by:

- the provision of service through a variety of modalities;
- hours of operation based on the needs of child and youth clients; and,
- inclusion of children and youth in the design of their individual service delivery.

Throughout our consultations, it was clear that services are most accessible and effective when provided in locations where children and youth already go and are comfortable. In general, the outreach-based approach of addictions counsellors was seen as preferable to the largely office-based services of mental health counsellors. Although mental health outreach services do exist in some communities, Child and Youth Services across the province should increase the capacity of mental health clinicians to meet with children and youth in settings more comfortable to them, thereby affording young people easier access to the service.

Various modalities for intake and the provision of both mental health and addictions services should be further explored, as "places where youth go" include online, virtual and text-based environments. While many children and youth prefer in-person service, others do prefer these modes of communication. We recognize that there are communities where it is geographically unfeasible to have a mental health and/or addictions clinician physically present on a regular basis. In these instances, we urge the health system to continue exploring ways in which virtual and text-based services can be made more accessible to youth – including ensuring they have access to the technology required for this purpose. Additionally, the expansion of virtual/text-based services could be used to widen the pool of clinicians available to young people so that they may find and access a clinician with whom they better connect and relate, even if they are based outside of their community.

Ideally, whichever modality is used, these services should further accommodate the needs of young people by being provided at times more meaningful to them.

"It is imperative that service provision be child-centered in that, to the furthest extent possible, children and youth be involved in decisions around the methods, locations and times that would be most meaningful to them,"

¹⁰⁴ Government of Canada. (2020). Canada-Saskatchewan Home and Community Care and Mental Health and Addictions Services Funding Agreement. (Retrieved from: <https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/saskatchewan.html>)

¹⁰⁵ Kutcher, S. and McLuckie, A. for the Child and Youth Advisory Committee, Mental Health Commission of Canada. (2010). Evergreen: A child and youth mental health framework for Canada. Calgary, AB: Mental Health Commission of Canada. (Retrieved from: https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/C%252526Y_Evergreen_Framework_ENG_1.pdf)

¹⁰⁶ McElvaney, R., Judge, D. & Gordon, E. (2017). The Primary Schools Counselling Study (PSCS): Demand and Provision of school-based counselling in Ireland. Dublin: Dublin City University

¹⁰⁷ Cooper, M. (2013). School-based Counselling in UK Secondary Schools: A review and critical evaluation. Glasgow: University of Strathclyde

¹⁰⁸ Cooper, M., Fugard, A., Pybis, J., MacArthur, K. & Pearce, P. (2015). Estimating effectiveness of school-based counselling: Using data from controlled trials to predict improvement over non-intervention change. *Counselling and Psychotherapy Research*, 15(4), 262-273.

The Advocate recognizes the need for clinicians to have consistency and predictability within their roles. However, it is imperative that service provision be child-centered in that, to the furthest extent possible, children and youth be involved in decisions around the methods, locations and times that would be most meaningful to them, and that service providers have the flexibility to accommodate these needs.

"A child's autonomous access to mental health or addictions services should not depend on where in the province they live or through which system they are seeking help."

Recommendation #6

The Ministry of Health, Ministry of Education, the Health Authorities and all school divisions adopt a consistent approach to "consent" for children and youth to receive mental health and addictions counselling based on the evolving capacities of the child rather than age.

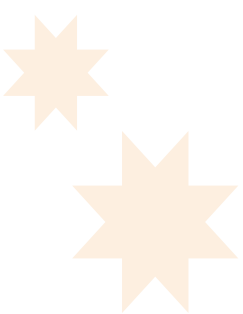
The right of children and youth to express their own views includes the right to participate in health care decisions.¹⁰⁹ Our findings, in addition to our office's regular advocacy activities, indicate that approaches to consent are inconsistent across the province and in many cases, are a barrier to children receiving needed services. A child's autonomous access to mental health or addictions services should not depend on where in the province they live or through which system they are seeking help.

All children and youth are equally entitled to have their rights respected. The 'mature minor doctrine' has been applicable in Saskatchewan since 2009.¹¹⁰ It is unacceptable that so much confusion and inconsistency of application still exist. There are many reasons why a young person may not be able to garner the consent of their parent(s)/caregiver(s) to access service, none of which outweigh the rights of the child.

This approach to consent must be grounded in the rights of the child and the common law applicable to services in Saskatchewan recognizing the ability of children and youth of any age to consent – on their own accord – to mental health and addictions counselling, provided that:

- their health care provider is of the opinion that the treatment is in the child's best interest;
- the child understands the details of the treatment, including the risks and benefits; and,
- the child can make an informed decision on their care based on this understanding.

This action would align with that taken by other provinces, such as British Columbia¹¹¹ and New Brunswick¹¹², that have codified recognition of this right into their provincial legislation.



109 UN Committee on the Rights of the Child. (2009). General Comment No. 12 (2009): The right of the child to be heard. CRC/C/GC/12 Geneva, CH: United Nations. (Retrieved from: <https://www.refworld.org/docid/4ae562c52.html>)

110 AC v Manitoba (Director of Child and Family Services), 2009 SCC 30, [2009] 2 SCR 181. (Retrieved from: <https://www.canlii.org/en/ca/scc/doc/2009/2009scc30/2009scc30.html>)

111 Government of British Columbia. Infants Act [RSBC 1996] Ch. 223. (Retrieved from: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96223_01)

112 Government of New Brunswick. Medical Consent of Minors Act, SNB 1976, C M-6. 1 (Retrieved from: <https://www.canlii.org/en/nb/laws/stat/snb-1976-c-m-6.1/latest/snb-1976-c-m-6.1.html>)

Should there be any hesitancy to recognize children's autonomy based on its implications towards other forms of medical treatment, the Committee on the Rights of the Child mitigated these concerns when it clarified that, "[t]he right to counselling and advice is distinct from the right to give medical consent and should not be subject to any age limit."¹¹³

Recommendation #7

The Ministry of Health and the Health Authorities provide in-home support services to families who require this service to maintain care for children with mental health and/or addictions related needs at home.

A significant concern identified throughout the themed findings involved the pressure on families/caregivers caring for young people with serious mental health problems and problematic substance use. Parents and caregivers described being overwhelmed by expectations and responsibilities, all of which are exacerbated by a lack of experience in mental health and/or addictions issues and the fear, guilt and worry experienced when trying to keep their child safe.

It was widely stated that more tangible supports are needed for these families, including adequately trained respite workers to assist with supervision, transportation to appointments, implementation of safety plans and other tasks. Increased availability of these services could reduce attendance at emergency rooms and the demand for inpatient beds when a young person's needs become too high for families to manage on their own. It may also provide much-needed support for youth and their families in circumstances where the young person attends an emergency room in crisis, but is not admitted, and at the time of discharge from an inpatient unit when intensive ongoing support is required.

While in-home services such as these are available through the Ministry of Social Services under *The Child and Family Services Act*, these services are limited and difficult to access. Additionally, involvement with the child protection system carries its own stigmas. Considering this need arises from a health issue, the burden of funding should be shared by the health system rather than falling solely to the Ministry of Social Services.

This recommendation supports that made by the **Mental Health and Addictions Action Plan to "improve the accessibility and coordination of supports for parents and families, including [...] respite."**¹¹⁴ It also aligns with direction from the Committee on the Rights of the Child to provide necessary supports to children and families to prevent placement in a hospital or institution,¹¹⁵ and would fill a gap in the province's stepped care approach.



UNCRC General Comment No. 15

In accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests. States should clarify the legislative procedures for the designation of appropriate caregivers for children without parents or legal guardians, who can consent on the child's behalf or assist the child in consenting, depending on the child's age and maturity.

113 UN Committee on the Rights of the Child. (2009). General Comment No. 12 (2009): The right of the child to be heard. CRC/C/GC/12 Geneva, CH: United Nations. (Retrieved from: <https://www.refworld.org/docid/4ae562c52.html>)

114 MHAAP recommendation 8.3.

115 UN Committee on the Rights of the Child (CRC). (2013). General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (Article 24), 17 April 2013, CRC/C/GC/15. pp. 8. (Retrieved from: <https://www.refworld.org/docid/51ef9e134.html>)

Recommendation #8

The Ministry of Health and the Health Authorities develop and lead a “middle-tier” care option to provide therapeutic residential placements for youth with mental health needs that are greater than can be managed in their home and/or with outpatient services, but who do not meet the criteria for acute psychiatric inpatient treatment.

This significant gap in the continuum of care is evidenced by the discrepancy between stakeholders’ calls for more inpatient psychiatric beds and observations by psychiatrists that most young people in mental health crisis are not acutely psychiatrically ill. Nonetheless, their crises arise because the needs of these youth are too high to be managed on their own.

Another type of resource is needed to provide a middle-tier service between outpatient services and inpatient psychiatric treatment. Should the previous recommendation on increased access to in-home respite services be accepted, this middle-tier resource is envisioned as the next step in a stepped care framework. This resource is needed when in-home respite services are not enough to keep youth at home, when a young person needs respite from triggers they face in the home, or to soften the transition between inpatient and outpatient care.

Currently, an accessible resource such as this does not exist in Saskatchewan for all youth who require it. This gap was also identified in the findings from our investigation into the case of Waylon. The Ministry of Health and the Saskatchewan Health Authority agreed but pointed to recent investments in three youth-specific Community Recovery Teams working to increase the capacity of Street Culture Project Youth Shelter in Regina, Egadz in Saskatoon and a future project in Prince Albert to support youth with intensive needs related to mental health and substance misuse.

Our office acknowledges these investments and the valuable service provided to youth accessing those programs. Although meeting a need, these supports are inaccessible to many youth as placement can often depend on involvement with the child protection system and do not provide the level of therapeutic support envisioned by this recommendation. Additionally, although its finding was not specific to youth, the Provincial Auditor reported that these teams had not reduced the hospital readmission rate for mental health patients.¹¹⁶

A residential resource in which youth can access therapeutic programming, life skills training, education, support with healthy coping strategies and family counselling could reduce pressures on current inpatient beds needed to treat acutely psychiatrically ill young people. Allowing youth time to work on their recovery in a supportive environment could also prevent relapses and subsequent visits to the emergency room.

116 Provincial Auditor of Saskatchewan. (2021). Report of the Provincial Auditor to the Legislative Assembly of Saskatchewan: 2021 Report - Volume 1. Regina, SK: Author.

One example of such a step-down resource is CASA House in Edmonton, Alberta.¹¹⁷ CASA House is operated by the non-profit organization CASA Child, Adolescent and Family Mental Health and is primarily publicly funded through Alberta Health Services. It provides an alternative to inpatient psychiatric hospital units through a four-month inpatient program supporting youth in grades 7-12 with significant mental health and/or addictions challenges who have not benefited as expected from previous clinical interventions. It provides all the programming mentioned above in an evidence-based and trauma-informed way. Families learn how to better support each other, and youth go home on weekends to practice these skills.

Alcohol and cannabis remain the most commonly used substances as self-reported by youth attending secure detox, however, crystal meth has increased substantially and ranks third.

Recommendation #9

The Ministry of Health and the Health Authorities formally evaluate the current detox and addictions treatment model to determine whether it is appropriate for meeting the current needs of youth in relation to the:

- evolving type and severity of problematic substance use;
- availability and accessibility of inpatient treatment;
- transitions between detox and inpatient treatment; and,
- transitions from inpatient treatment to the community.

The type and severity of substance use by youth is quickly evolving. The deaths of individuals of all ages where methamphetamine and/or fentanyl were the sole or a contributing factor are on the rise.¹¹⁸ While young people are not dying because of drug or alcohol toxicity at the same rate as adults, the use of these substances is widespread among youth in Saskatchewan. Alcohol and cannabis remain the most commonly used substances as self-reported by youth attending secure detox, however, crystal meth has increased substantially and ranks third. Stakeholders expressed concerns that the current detox and treatment model may not be as effective as it could be in addressing the impacts of these substances.

As part of its evaluation, the province ought to give serious consideration to the development of a treatment and rehabilitation centre for young people specializing in crystal meth. Such a facility has recently been created for adults at St. Joseph’s Hospital in Estevan, SK. If young people can receive adequate treatment, it may mitigate the consequences of ongoing and entrenched substance misuse into adulthood. This suggestion aligns with a recommendation made by youth connected to the Safe Community Action Alliance Crystal Meth Working Group, which called for **“facilities for a crystal meth specific treatment and rehabilitation centre [...] that offers transportation, family accommodation, optional cultural programming, and access to Elders.”**¹¹⁹

117 <https://www.casaservices.org/casa-house>

118 Saskatchewan Coroners Service. (February 2022). Drug Toxicity Deaths Saskatchewan, 2016 to 2022. (Retrieved from: <https://publications.saskatchewan.ca/#/products/90505>)

119 Safe Community Action Alliance Crystal Meth Working Group. (2020). A Community Response to Crystal Meth in Saskatoon, Saskatchewan, SK: Author (Retrieved from: <https://static1.squarespace.com/static/5605b57ee4b09976d54b042c/t/601cae97ca18a4036ef6dc44/1612492501005/CMWG+Final+Report+Feb2021+revision.pdf>)

The province and the health system ought to explore whether facilities for the secure detoxification and inpatient treatment of youth can be expanded more equitably across the province to address barriers related to accessibility, fear of being far from home, difficulty connecting back to supports in one's home community and a lack of culturally responsive services.

Additional ways in which the system could address concerns identified by stakeholders is to determine whether there are enough physicians, distributed geographically, who are willing and capable of conducting timely addictions assessments for the purposes of securing a warrant under *The Youth Drug Detoxification and Stabilization Act*, and take action to increase capacity if there is not.

Despite the assertion of the health system that there are little to no wait times for youth detox or inpatient addictions treatment, this does not reflect the experience of many participants and stakeholders who report that these services are not available in a timely manner. This was also a finding made in the **Mental Health and Addictions Action Plan in 2014**. The health system must explore the impetus behind these concerns and address them. Like the approach taken in the **MHAAP**, we **emphasize the need for access to addictions supports to "meet or exceed public expectations."**

Transitions from inpatient services to community must be improved through more comprehensive discharge planning, the development of transition houses where young people can return (in or close to their home communities) when needing a safe place to stay sober, more intensive follow-up by addictions outreach workers following discharge from detox and treatment and – lastly – support for the development of youth-specific community resources such as Narcotics Anonymous and Alcoholics Anonymous. Some of these elements also reflect recommendations made by youth in the Safe Community Action Alliance Crystal Meth Working Group to "[e]stablish an out-patient, supported-living and housing program for addicts and implement a Managed Crystal Meth Program [...]." ¹²⁰

Recommendation #10

The Ministry of Health and the Health Authorities enhance and expand culturally appropriate services that are integrated within the continuum of mental health and addictions services, including:

- **broader representation of Indigenous service providers in Western-based models of treatment; and,**
- **greater availability of wellness and healing approaches grounded in Indigenous ways of knowing across urban, rural, and remote communities.**

There are many Indigenous communities in Canada that have leveraged their language, culture, land, and resources to enhance wellness in the mind, body, emotions, and spirit of their members, including their young people. It is imperative that the Ministry of Health and the Saskatchewan Health Authority intensify their efforts to implement the MHAAP recommendations to partner with and learn from Indigenous peoples in the planning and delivery of mental health and addictions

"As someone who is over 18 and is starting to, I guess, have those final development brain changes and I'm going through my second wave of "Oh wow...this is not good." This is really hard to figure out. It is a really complex issue. It is hard enough to get help for, like, basic mental health issues. [...] Counselling is atrocious to deal with right after you turn 18."

- Youth Advisory Council

services. As we heard from participants in this project, although there are pocketed programs providing culturally appropriate services, access to these programs is limited across the province.

Indigenous healing approaches must be elevated within the continuum of mental health and addictions services for Indigenous children and youth. In addition, the Saskatchewan Health Authority should engage in a systematic review to understand the reasons Indigenous practitioners are not pursuing education and/or employment within Western-based models of treatment. Based on the findings of its review, it must identify targeted strategies for altering these circumstances to increase the complement of Indigenous counsellors to work effectively with Indigenous youth struggling with their mental health and/or addictions. A geographical scan of current services should be conducted to identify areas needing special attention for Indigenous children and youth and any other barriers to its effectiveness should be addressed.

Recommendation #11

The Ministry of Health and the Health Authorities improve transitions from child and youth to adult mental health and addictions services by:

- **increasing the age of transition to 25; and,**
- **allowing young adults to maintain treatment by their child/youth service providers until they are connected to a parallel adult service.**

The **Mental Health and Addictions Action Plan** recommended improvement to transitions within and across services, including from youth to adult mental health and addictions services. Yet, we continued to hear of the same struggles experienced by youth as they reach their 18th birthday. Concrete action is required to prevent young people from falling through the cracks due to this age-based discrimination. These pitfalls could be avoided if transitions are based on the readiness of the client, are carefully planned for and delayed until there can be a seamless hand-off from one system to the other. No one should be left without a needed service simply because of their age.

Recommendation #12

The Ministry of Health and the Health Authorities complete provincial implementation of the electronic Mental Health and Addictions Information System (MHAIS) to guarantee all those involved with youth mental health and addictions services across community, emergency, and inpatient services have access to the information required to provide seamless, effective service in the best interests of children and youth.

The importance of information-sharing among health providers was highlighted across several themes identified by stakeholders. Mental health and addictions counsellors reported being unaware when their clients attended an emergency room in crisis and, therefore, unable to support them in that crucial period.

"Mental health and addictions counsellors reported being unaware when their clients attended an emergency room in crisis and, therefore, unable to support them in that crucial period. "

Counsellors reported not being informed in a timely manner when their clients had been admitted to and discharged from an inpatient psychiatric unit, what services young people received while there, or what safety plan may have been developed upon discharge.

A lack of accessible information was also identified as a barrier when young people move between regions of the province, or when youth from the North come South to access services.

When we gathered our primary data, the province was piloting the Mental Health and Addictions Information System (MHAIS). It has since been made available across most community services and is currently being piloted within select adult inpatient facilities. The Government of Saskatchewan identifies this action as supporting the Mental Health and Addictions Action Plan recommendations. The Ministry indicates that its long-term goal is to bring all community and inpatient services onto this system.

The Advocate is encouraged by this progress and urges that further advancement toward implementation within child and youth hospitals and facilities be a high priority. This aligns with a recommendation put forward by the Provincial Auditor.¹²¹ In particular, the Ministry and Health Authorities must ensure that any information-sharing system in place empowers frontline clinicians across emergency, community and

inpatient services to provide seamless and consistent support to the children and youth it serves. This includes having all providers be aware of, and working from, the same safety plan and clinical recommendations for ongoing care and/or strategies developed for the young person. Furthermore, to ensure complete information relevant to each patient is available to all their mental health care providers, the Ministry and Health Authorities should also implement the Provincial Auditor's complementary recommendation to "[d]evelop a strategy to collect mental health and addictions client service information in its health record system from healthcare professionals outside of the Authority (e.g., psychiatrists).¹²²

Recommendation #13

That all child-serving Ministries - including Health, Education, Social Services, Justice and Corrections - and the Health Authorities develop and implement an integrated service delivery model to enhance communication and coordination to support better outcomes within the mental health and addictions continuum of care services provided to children and youth.

Communication and information-sharing between various child-serving systems was also a substantial theme identified by stakeholders. This was also a significant finding in our investigation into the death of Waylon. There are multiple individuals across sectors involved in supporting the well-being of a young person and, while everyone may have a piece of the puzzle, it is often the case that no one has the full picture of what is going on for a young person.



"Our office, in conjunction with advocate offices across Canada, have long advocated for an integrated service delivery model that eradicates barriers between systems and reduces fragmented services to meet the needs of children, youth and families. "

The various child-serving systems have policies directing that service providers communicate with each other. However, time constraints and uncertainty around how much information can be shared often hinder this process. Certainly, children and youth have the right to privacy. But they also have the right to be protected from all forms of harm. Better understandings of what service providers are permitted to share under *The Health Information and Protection Act*, and more coordinated processes of communication are needed to ensure children and youth receive holistic services and that important pieces of information do not fall through the cracks – even if systems are overloaded and providers are busy.

Our office, in conjunction with advocate offices across Canada, have long advocated for an integrated service delivery model that eradicates barriers between systems and reduces fragmented services to meet the needs of children, youth and families. In 2019, the Canadian Council of Child and Youth Advocates¹²³ released *A National Paper on Youth Suicide*,¹²⁴ which collated investigative findings from across Canadian jurisdictions, and observed that there is "little direct communication between child-serving systems, and the coordination efforts were insufficient to meet the needs of the youth" and "youth at an elevated risk for suicide can become even more vulnerable when systems of care for children and youth are not well-integrated."

That report highlighted the Integrated Services Delivery model adopted by the Government of New Brunswick which integrates all child and youth services across four provincial ministries. This model is regarded across the country as a leading best practice for addressing issues of privacy and confidentiality to allow professionals from health, education, child welfare and justice to participate fully on one of several child and youth teams. Through this approach, one file is created for each youth instead of multiple plans and files held separately by the various service providers involved in their life. Early evaluations of the pilot project showed that integrated service delivery allowed for appropriate services to be delivered to youth efficiently and collaboratively, resulting in decreased service wait times.^{125 126} Our office urges Saskatchewan to consider this, or a similar model, to strive for better integration among services to children and youth in our province.

The province is moving towards implementation of an "Integrated Youth Services" model in which rapid access to youth-targeted services focusing on prevention and early intervention will be made available in a single location in up to three communities. This is very positive and aligns with statements by participants that services are more coordinated when they are co-located. It remains important, however, that all services to children and youth – no matter where the community or building are located – have the capacity to communicate and coordinate with one another in the best interests of the child.

¹²³ The CCCYA is an association of children's Advocates, Representatives and Ombudspersons from across Canada who are independent officers of the legislatures in their respective jurisdictions with mandates to promote and protect children's human rights through complaint resolution, advice to government, amplification of child and youth voices, and public education functions. CCCYA members work together to identify areas of mutual concern and address national issues. (<http://www.cccya.ca/content/index.asp>)

¹²⁴ Canadian Council of Child and Youth Advocates. (2019). *A National Paper on Youth Suicide*. Saskatoon, SK: Author. (Retrieved from: <http://www.cccya.ca/Images/english/pdf/CCCYA%20National%20Suicide%20Paper%20Final%20September%2025%202019.pdf>)

¹²⁵ Morrison, Bill, and Peterson, Patricia. (2017). *Story of Transformation in Youth Mental Health in the Province of New Brunswick*. Government of New Brunswick. (Retrieved from: <https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/MentalHealth/our-story.pdf>)

¹²⁶ New Brunswick Child and Youth Advocate. (2021). *The Best We Have to Offer*. Fredericton, NB: Author. (Retrieved from: <https://static1.squarespace.com/static/60340d12be1db058065cd10/t/6141d15324d76514ebbe808b/1631703592266/The+Best+We+Have+to+Offer.pdf>)

The Saskatchewan Children and Youth First Principles¹²⁷ direct that “*all children and youth in Saskatchewan are entitled to [...] [b]e treated as the primary client, and at the centre of, all child-serving systems.*” The Government of Saskatchewan adopted these principles in 2009, thereby committing the government to their implementation. It is clear from our widespread consultations that the child-serving systems in our province are up to the task of putting children at the centre of their work. All that is required is the framework and support to do so.

Recommendation #14

The Government of Saskatchewan develop a ‘Children’s Strategy’ to address and improve prevention related to the social and environmental factors that negatively impact the well-being of children and youth. This strategy must include the participation of all child-serving ministries and a designated official to lead the process.

Respecting the right of the child to have their best interests be a *primary consideration* in all matters that concern them requires their interests to be top of mind for every decision-maker in every system that touches their lives. This consideration must occur in an integrated, coordinated and systemic way.

Building on the former Saskatchewan Child and Youth Agenda – into which the government made significant investments – a Children’s Strategy elevates children’s issues to the forefront of government priorities and strategies to address societal issues in a coordinated and integrated manner. It also conveys publicly that children, as our future generation, matter. It reminds us that there is a high onus on the government to ensure positive outcomes for the health and well-being of children in Saskatchewan.

UNCRC Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare

institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

Poor mental well-being and addiction are multifaceted and often the culmination of breakdowns in several different areas, with suicide or overdose being the gravest outcomes. When the driving factors behind these breakdowns for children can be systematically addressed, overall well-being increases and reliance on the mental health and addictions system is reduced. A Children’s Strategy is a conduit for the Ministries of Health, Education, Justice and Social Services as well as other child-serving systems, such as the Health Authorities and school divisions, to join forces to improve outcomes for children. In turn, this coordination will alleviate one Ministry being solely responsible to deal with the fall out of a broken system that continues to perpetuate decades of gaps and barriers to service.

This Strategy would offer a mechanism within which to operationalize and oversee the integrated services delivery model also recommended here – but its mandate would go further in that consideration of the rights and interests of children in government activities extends beyond mental health and addictions services. As indicated at the outset of this report, children’s rights are interdependent and indivisible. To protect and fulfil the right of children and youth to the highest attainable standard of health, their rights in all domains must be upheld.

¹²⁷ Saskatchewan Advocate for Children and Youth. Saskatchewan Children and Youth First Principles. (Available at: <https://www.saskadvocate.ca/children-youth-first/children-youth-first-principles>)

Through a Children’s Strategy, partners will be better able to assess the broad implications to children of changes to legislation, policy, and practice in all areas by conducting comprehensive Child Rights Impact Assessments as directed by the Committee on the Rights of the Child¹²⁸ and operationalized by UNICEF Canada.¹²⁹

This Strategy must remain active and not suffer the same fate as the Saskatchewan Child and Youth Agenda. It must not drift with a change of government or fall to the bottom of the government’s priorities when resources are lessened.

The Advocate is encouraged that there is already an appetite for all sectors to work together to support children’s well-being. This is evidenced by recent collaborative efforts including the movement towards “Integrated Youth Services” and the government’s statements in its suicide prevention plan and legislated strategy that concerted, cross-sectoral action and accountability is required to address mental health in Saskatchewan.

Finally, it is imperative that a designated lead official be attached to a Children’s Strategy to ensure its forward progression, continued momentum, and longevity. This Strategy must remain active and not suffer the same fate as the Saskatchewan Child and Youth Agenda. It must not drift with a change of government or fall to the bottom of the government’s priorities when resources are lessened.

¹²⁸ Committee on the Rights of the Child. (2003). General Comment No. 5 (2003) General measures of implementation of the Convention on the Rights of the Child. Geneva, CH: United Nations. CRC/GC/2003/5 (Retrieved from: <https://www.refworld.org/docid/4538834f11.html>). para.12

¹²⁹ UNICEF Canada. (2015). Child Rights Impact Assessment Community of Practice. Toronto, ON: Author. (Retrieved from: <http://cricommunity.org/>)

6.0

Conclusion

For the reasons set out in this report, our office has placed a high priority on working toward influencing and recommending better outcomes for the mental health and well-being of children and youth in Saskatchewan. Gathering the perspectives on youth mental health and addictions services from all sectors across the province was key to bringing life to peoples' experiences with mental health barriers and the continued impacts resulting from these obstacles. The vast number of participants that volunteered is a testament to the commitment and dedication of individuals in our province who want to see enhanced supports for our young people.

The findings clearly lay down the path for what is needed to get services to children and illustrate that, despite the investments of the past, there are key areas that require urgent attention which can take some pressure off the acute care system and make an immediate difference in the lives of children who desperately need service. Working in a strategic, streamlined, integrated manner to address these pressure points and get services to children quicker is key to any forward-moving changes. Getting back to putting children at the fore of services – with Ministries that serve children working together – across sectors in a collaborated and integrated manner is also key to ultimately reducing the factors that lead to poor child well-being. A Children's Strategy would accomplish this goal.

We placed high importance on honouring the reports from Saskatchewan that came before – namely, *It's Time for a Plan for Children's Mental Health (2004)* and *Working Together for Change: A 10 Year Mental Health and Addictions Action Plan for Saskatchewan (2014)*. We know some major changes and system goals have been acted upon since the release of these reports, but the participants' insights and direct experiences tell us that a renewed dialogue on improving outcomes for child and youth well-being is imperative.

The themes presented in this report are comparable to those identified in bodies of work completed by Advocate offices in other jurisdictions, specifically British Columbia,¹³⁰ New Brunswick,¹³¹ and Nunavut.¹³² and we know that nationally, all provinces and territories grapple with many of the issues presented here. As recognized in New Brunswick, Saskatchewan also needs a shared vision akin to the one described in the Saskatchewan Child and Youth First Principles #7 – where children are “treated as the primary client, and at the centre, of all child-serving systems.” In our investigation of service provision to Waylon, we pieced together the various public services provided to Waylon from 10 different files. The circumstances in which Waylon's situation escalated without service providers coming together to problem solve in a meaningful way, illustrate that systems are not working together as well as they could.

Mental health issues facing specific groups of children – refugee and immigrant children, children and youth dealing with questions surrounding sexuality or gender identity, eating disorders, bullying or other traumas and those facing transitions – require thoughtful strategies for inclusion in any system undergoing changes. The finding on culturally appropriate services for Indigenous children and youth emerged from the data in a noticeable way.

¹³⁰ British Columbia Representative for Children and Youth. (2013). Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.. Victoria, BC: Author. (Retrieved from: https://rcybc.ca/wp-content/uploads/2019/05/still_waiting.pdf)

¹³¹ New Brunswick Child and Youth Advocate. (2021). The Best We Have to Offer. Fredericton, NB: Author. (Retrieved from: <https://static1.squarespace.com/static/60340d12be1db058065cdc10/t/6141d15324d76514ebbe808b/1631703392266/The+Best+We+Have+to+Offer.pdf>)

¹³² Nunavut Representative for Children and Youth. (2019). Our Minds Matter: A Youth-Informed Review of Mental Health Services for Young Nunavummiut. Iqaluit, NU: Author. (Retrieved from: https://rcynu.ca/sites/rcynu.ca/files/RCYO_MHReview_EN.pdf)

The quotes presented in this theme and consultations with our Elder Advisory Council have greatly enhanced our understanding of the power fueled by cultural teachings and connection with Elders that can benefit Indigenous children and young people to address their challenges with mental health and problematic substance use. This may also alleviate some pressure on the child-serving systems if leveraged properly. Reconciliation should be the foundational principle for Indigenous and non-Indigenous peoples to work together. The Truth and Reconciliation Calls to Action around health could be a jumping point to eliminate any obstacles to change, especially in relation to increasing the representation of Indigenous professionals employed in the mental health and addictions system.

Whether one's role is parent/caregiver, teacher, counsellor, psychologist, psychiatrist, corrections staff, social services staff or part of the leadership within child-serving ministries, this report should be employed to build upon current practices and better support young people. While the Advocate's formal recommendations do not encompass every possible solution to the barriers identified, there is much to draw from within each themed finding as presented by participants that could be put into policy and practice.

Our young people crave knowledge about mental health and problematic substance use, so they can be empowered with the understanding of what is happening to themselves, their peers, siblings, and others. Mental Health Capacity Building is a promising initiative that promotes positive mental health of students in the school setting and has the potential to reduce the burden the mental health and addictions system is currently experiencing. However, targeted intervention in places accessible to young people is also necessary. The importance of engaging young people in decisions affecting them and their mental health cannot be overstated. When our own Youth Advisory Council learned about the findings in this report, their feedback validated further the perceptions of the larger stakeholder group:

There's still a lot of stigma around seeking treatment, and the system is a lot more focused on damage control than crisis prevention. Obviously, it's super important that we have those systems for when things get bad, but we really need to improve things so that people don't get to the point where they need those emergency supports.

- Youth Advisory Council

Regardless of one's socio-economic, ethnic or cultural background, we all want our children to get the help needed in a timely way and for youth to enter adulthood with opportunities to live a good life and live to their full potential. There are roadmaps, such as the MHAAP and other works, that show us the way. This report – and all the participants who graciously provided their voices to it – contributed to our understanding of how to enhance the chances of reaching that destination. We hope this report will help decision-makers to see the impact these continuing barriers have on the lives of children, the urgency with which previous recommendations must be implemented and the reasons why all systems involved must continue to make child and youth well-being a priority. We know what to do, we just must do it. Our children cannot wait any longer.



Mental Health and Addictions Resources

If you or someone you know is in need of support with mental health or addictions, please reach out to one of these FREE resources:

In an Emergency:

- Call 911 and/or go to your nearest hospital emergency department

Child and Youth Community Mental Health and Addictions Counselling:

- Saskatchewan Health Authority:
<https://www.saskatchewan.ca/residents/health/accessing-health-care-services/health-care-facilities>
- Athabasca Health Authority: (306) 439-2200

HELPLINES:

811 – Access HealthLine

- Phone: 811 or 1-877-800-0002
- 24 hours a day / 7 days a week

Kids Help Phone

- Phone: 1-800-668-6868
- 24 hours a day / 7 days a week
- Text: Text the word "CONNECT" to 686868
- You do not need a data plan, Internet connection or an app to use it.
- 24 hours a day / 7 days a week
- Online Chat: Go to website: <https://kidshelpphone.ca/need-help-now-text-us/>
- NOTE: This option is not 24/7

First Nations and Inuit Hope for Wellness Help Line

- Phone: 1-855-242-3310
- 24 hours a day / 7 days a week
- On request, telephone counselling can be provided in: Cree, Ojibway & Inuktitut
- Online chat: Go to website: <https://www.hopeforwellness.ca/>



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