



# **Horizontal Integration to Improve Youth Mental Health Care In Canada**

IHE Innovation Forum XIV  
Edmonton: November 2015  
Dr. Stan Kutcher

# YOGI BERA-ism

**IT WAS IMPOSSIBLE TO GET A CONVERSATION GOING, EVERYBODY WAS TALKING TOO MUCH**



# Mental Health Status of Children and Youth

- **Most Canadian children and youth are mentally well:**

- Three out of four Canadians aged 12-19 years rate their mental health as very good or excellent
- 8% of youth aged 15-24 years described their mental health as fair or poor
- In 2013–2014, 5% of emergency department visits and 18% of inpatient hospitalizations for children and youth aged 5-24 years in Canada were for a mental disorder

Source: CIHI Care for Children and Youth with Mental Disorders (May 2015 Report)





# Vital Signs Canada: Nova Scotia Report

## Life Satisfaction

- In 2013, 98% of Nova Scotia's youth (aged 12-19 years) reported being satisfied or very satisfied with their lives compared to 96.3% nationally.

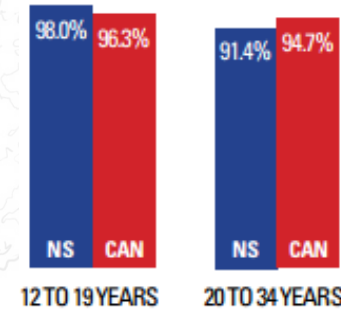
## Perceived Mental Health

- In 2013, 77% of Nova Scotia's youth (aged 12-19 years) reported their mental health as either "very good" or "excellent" compared to 75.4% nationally.

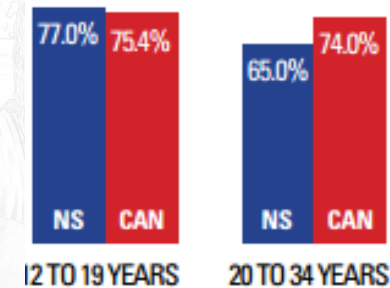
## Perceived Overall Health

- In 2013, 74.7% of Nova Scotia's youth (aged 12-19 years) reported "very good" or "excellent" overall health compared to 68.9% nationally.

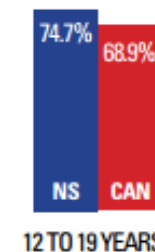
Life Satisfaction, Satisfied or Very Satisfied (2013)



Perceived Mental Health - Very Good or Excellent (2013)



Perceived Overall Health - Very Good or Excellent (2013)

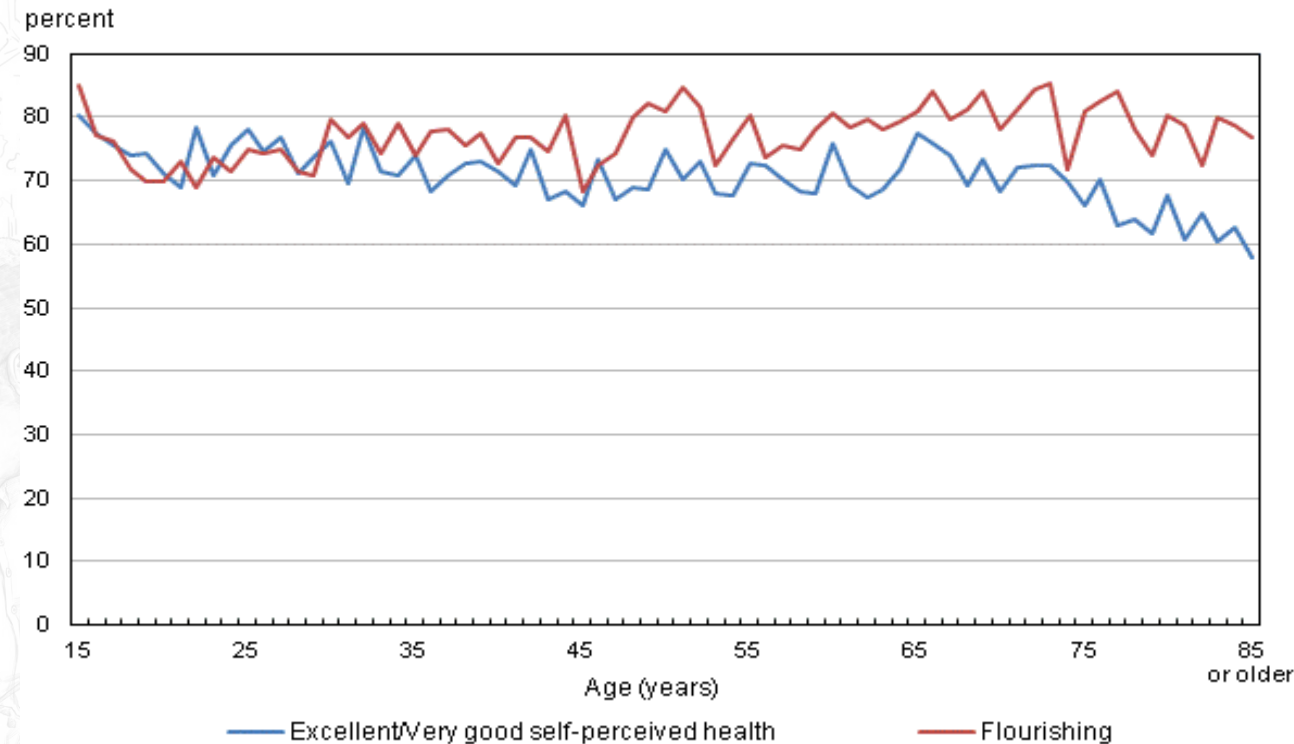




# Positive Mental Health and Mental Illness

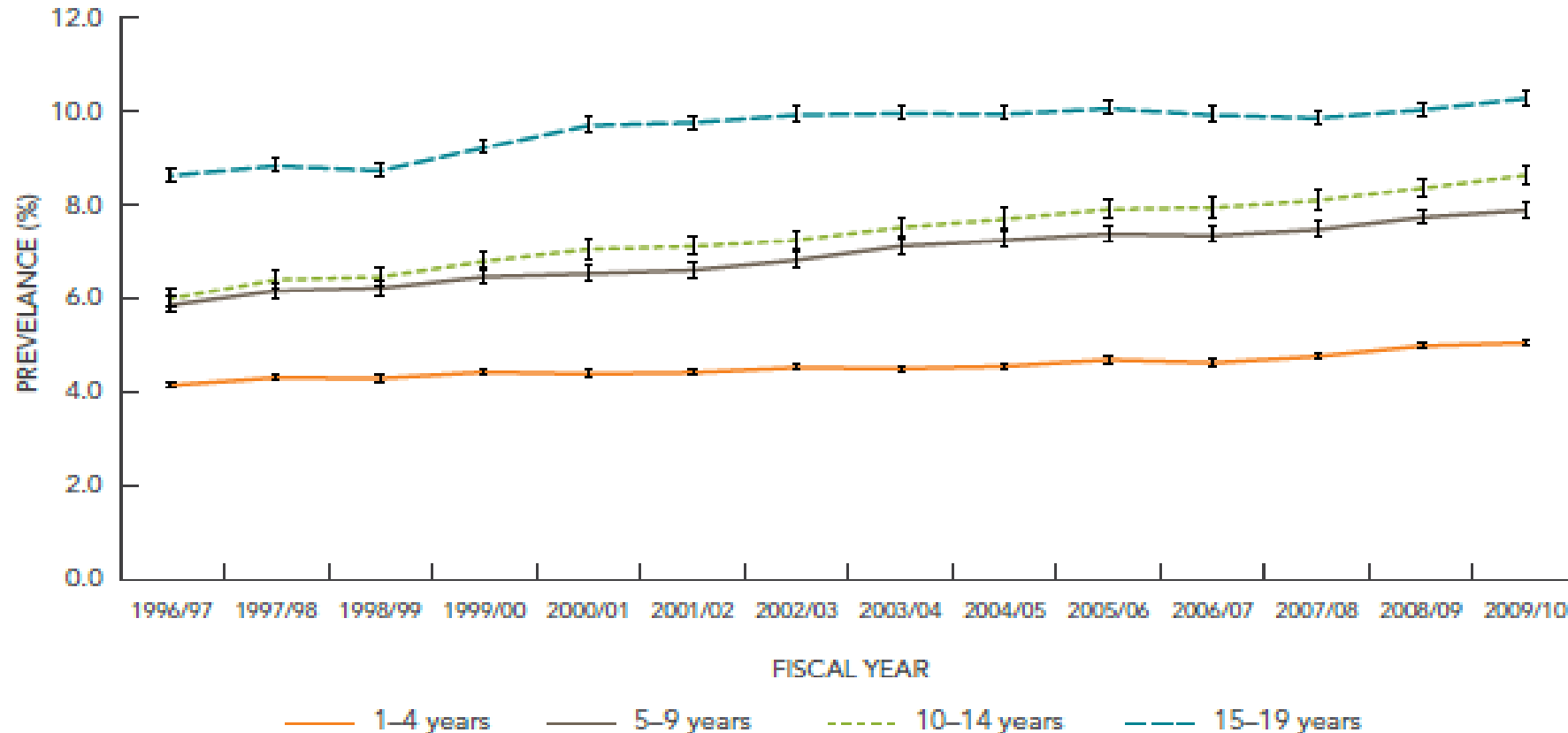
- According to Statistics Canada (2012), 76.5% of Canadians were classified as having flourishing mental health.
- Percentage of flourishing mental health in the United States, the Netherlands, South Africa, France and Korea were lower – ranging from 11.7%-69.1%.
- Approximately 72.5% of Canadians aged 15 or older (19.8 million) were categorized as having complete mental health (complete mental health is defined as both flourishing and being free of mental illness).

Percentage reporting excellent or very good self-perceived mental health and prevalence of flourishing mental health, by age, household population aged 15 or older, Canada excluding territories, 2012



Source: 2012 Canadian Community Health Survey, 2012 Canadian Community Health Survey - Mental Health.

**FIGURE 1:** Age-specific annual prevalence (%) of the use of health services for mental illness among people aged 1 to 19 years, Canada,\* 1996/97 to 2009/10



Increase in the prevalence of the use of mental health services between 1996-97 to 2009/10

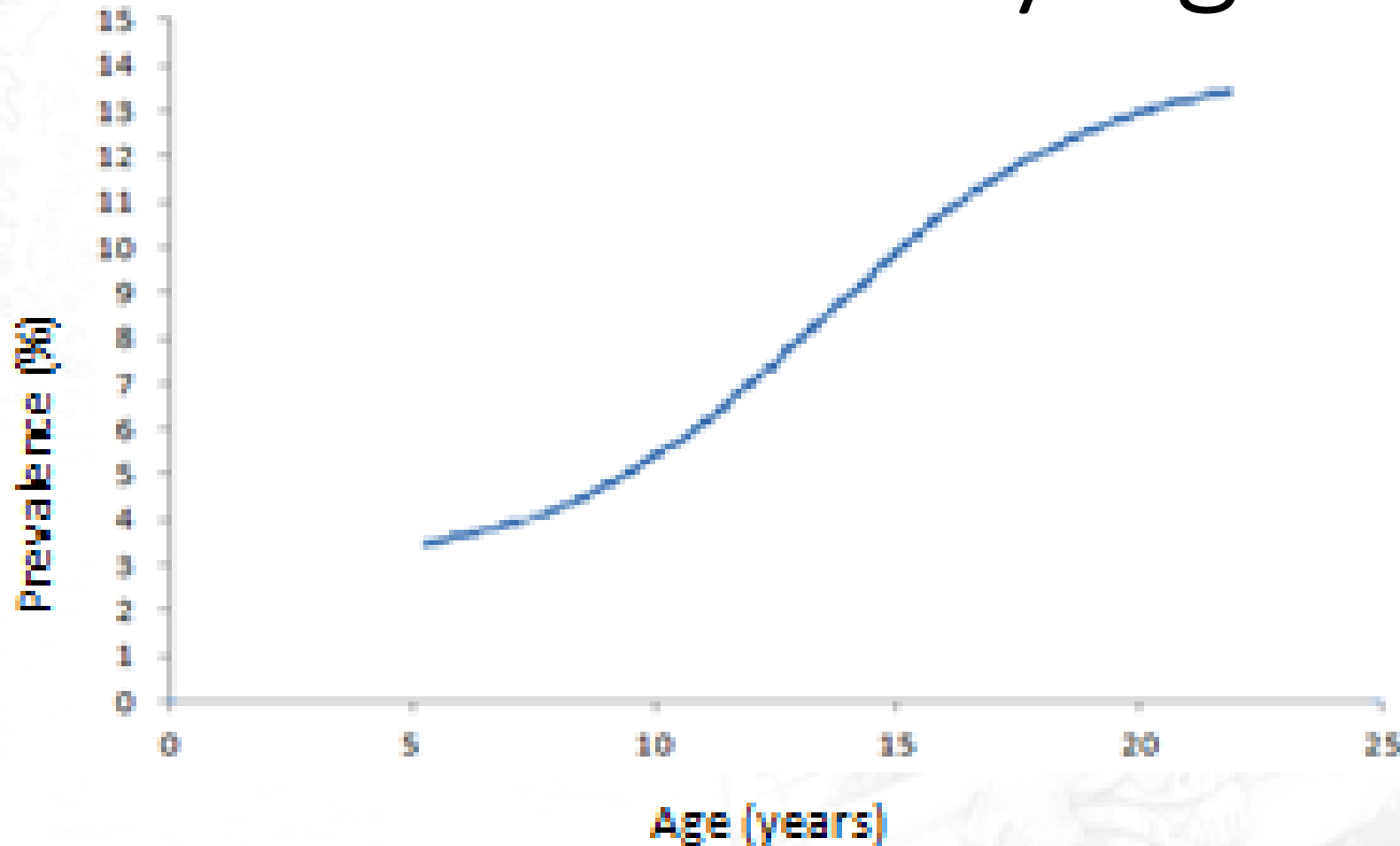
- May be due to **a)** real increase of number of cases OR **b)** increase in awareness of mental illness among children

**NOTES:** The 95% confidence interval shows an estimated range of values which is likely to include the true prevalence 19 times out of 20. \* Data do not include NU and YT.

**SOURCE:** Public Health Agency of Canada, using Canadian Chronic Disease Surveillance System data files contributed by provinces and territories, as of September 2013.

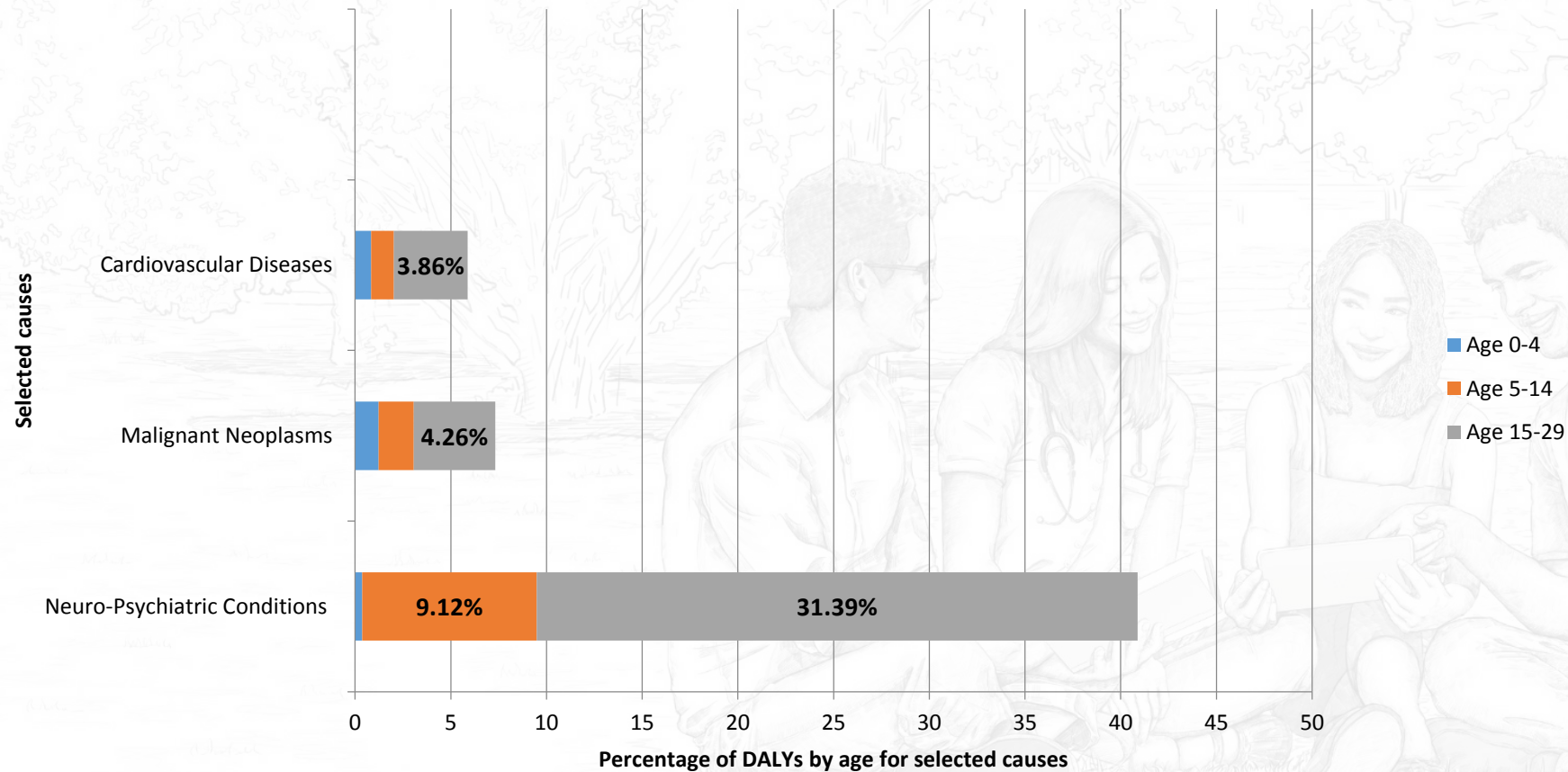


# Increasing Prevalence of Mental Disorders by Age



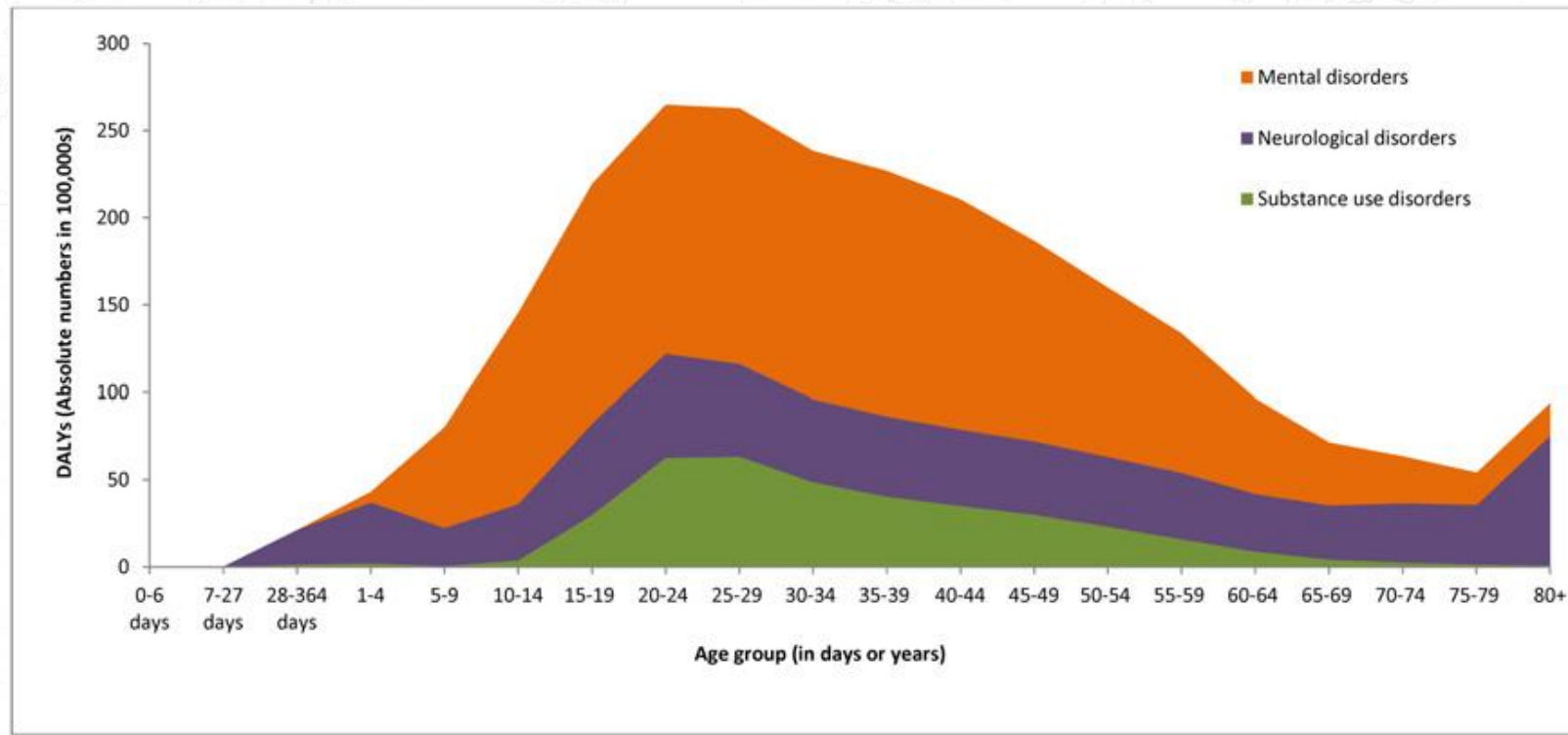


# WORLD: DALYS IN 2012 ATTRIBUTABLE TO SELECTED CAUSES BY AGE



World Health Organization. (2014). WHO methods and data sources for country-level causes of death: 2000-2012.

# ABSOLUTE DALYS ATTRIBUTED TO MENTAL, NEUROLOGICAL & SUBSTANCE USE DISORDERS, BY AGE, 2010



Note: DALYs = disability-adjusted life years.





# MENTAL ILLNESSES, PHYSICAL ILLNESSES AND SUICIDE



Diabetes  
Heart disease and stroke  
Respiratory conditions  
Suicide

Untreated mental illnesses are strong independent predictors of reduced life expectancy due to associated medical conditions, such as diabetes, heart diseases and stroke, respiratory conditions, and suicide.

R. Rugulies, "Depression as a Predictor for Coronary Heart Disease: A Review and Meta-Analysis," *American Journal of Preventive Medicine* 23 no. 1 (2002): 51-61





**WHAT SHOULD WE BE DOING?**

**OUR BIGGEST PROBLEM IS NOT  
YOUTH MENTAL HEALTH, IT IS THE  
PROVISION OF EQUITABLE, RAPID  
ACCESS TO BEST EVIDENCE BASED  
MENTAL HEALTH CARE FOR YOUTH  
WHO HAVE A MENTAL ILLNESS**



# Our Biggest Challenge!

How to configure what we are currently doing to better provide rapid and equitable access to best evidence based mental health care to all Canadian young people and their families?





# Our Parameters:



- Few new additional resources
- Current components of systems of care not likely to change drastically – institutions
- Must obtain a good ROI
- Address inequities (better society)
- Demonstrate success (measure, measure, measure: transparent regular reporting)
- Innovation while we wait for Invention
- Simple
- Sustainable
- System Strengthening – **HUMAN RESOURCES COMPETENCY ENHANCEMENTS THE KEY**
- Relatively inexpensive
- Effective
- Time sensitive
- Politically doable; non-partisan
- Much better than what we have



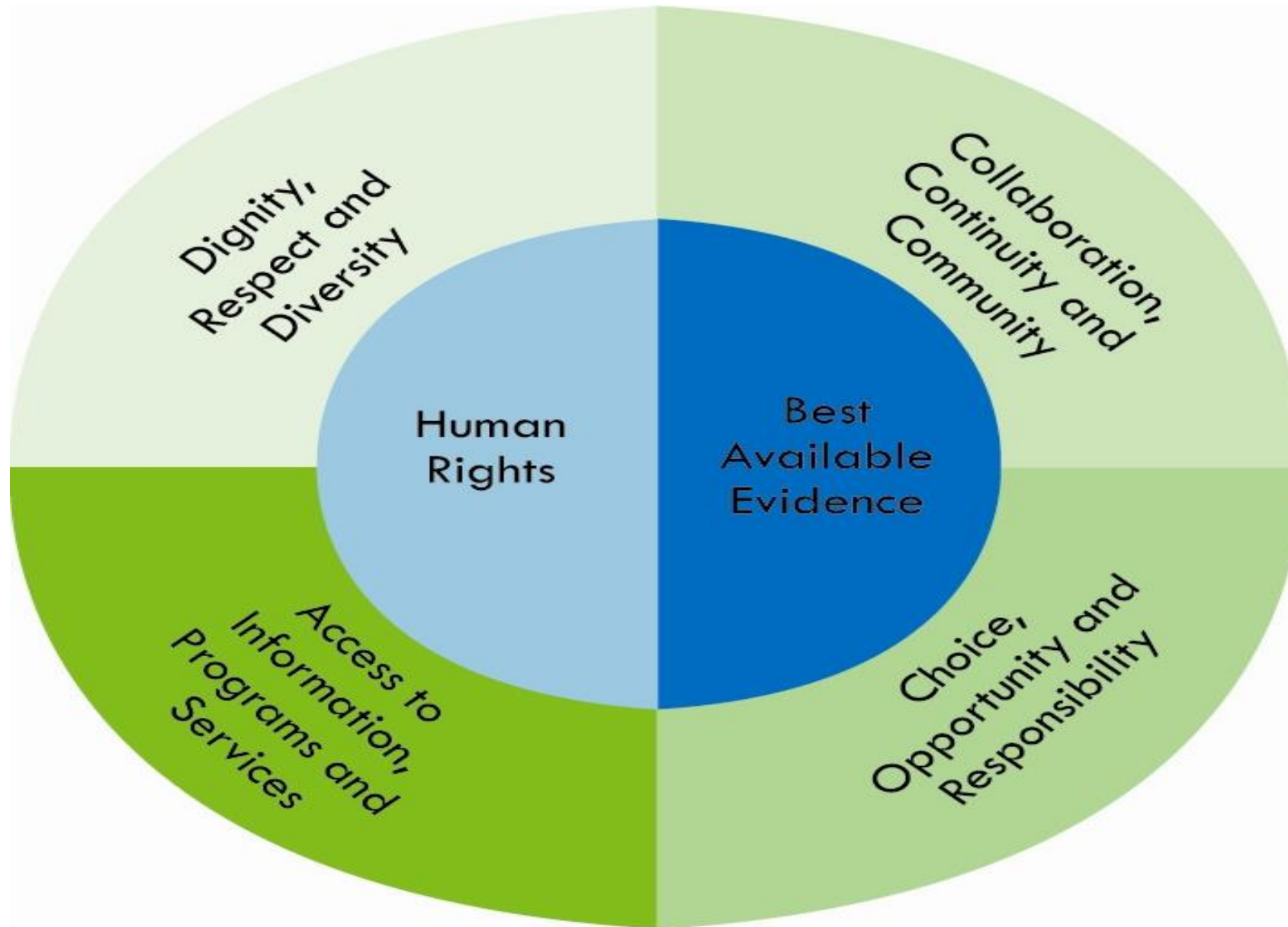
# WHAT WE HAVE TO DO!



# Evergreen Framework: MHCC

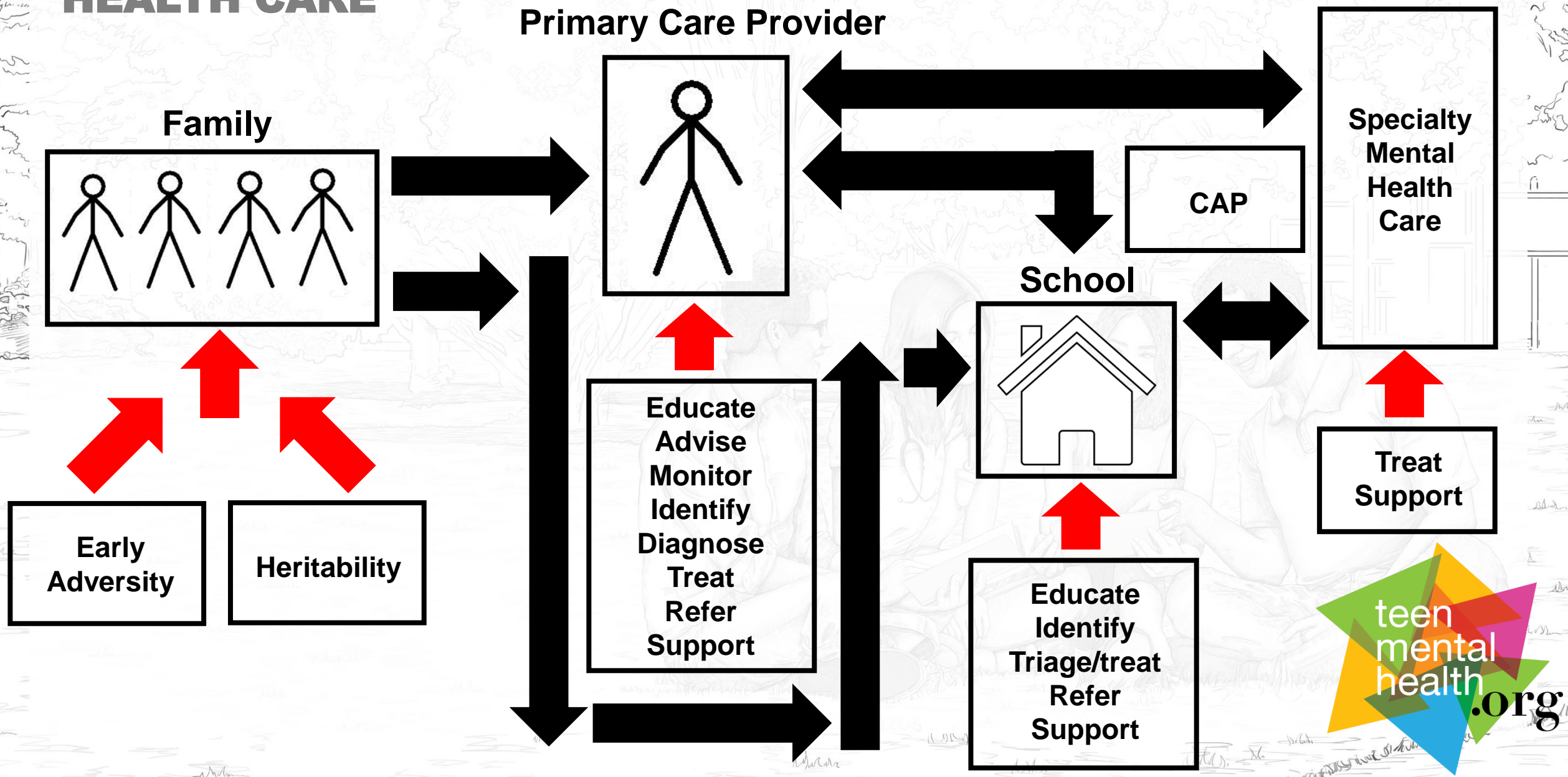


# Evergreen's Values

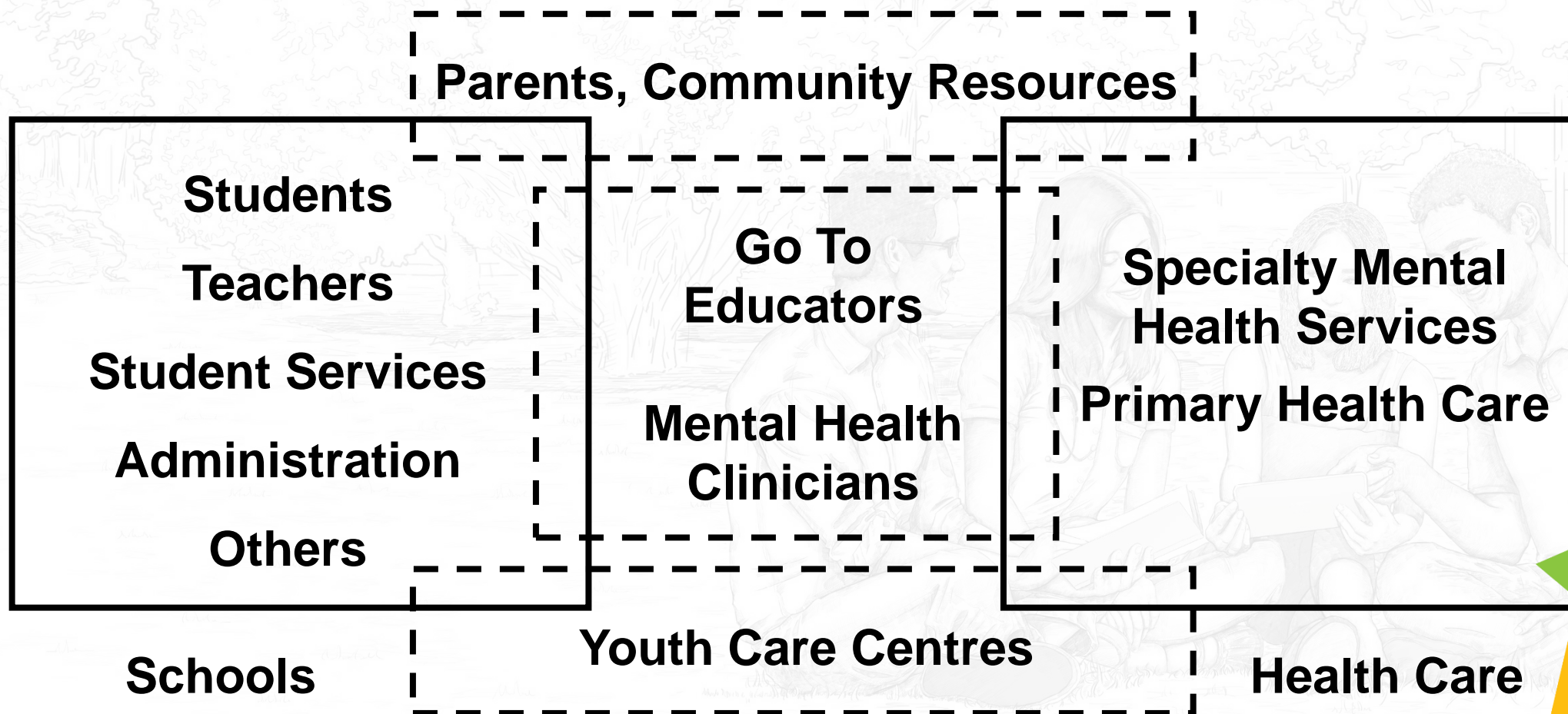




# HORIZONTALLY INTEGRATED PATHWAY TO YOUTH MENTAL HEALTH CARE



# LINKING EDUCATION & HEALTH CARE SYSTEMS





**Treatments and Care**

**Health Promotion**

**Prevention**

**Mental Health Literacy**





# Impact of Health Literacy

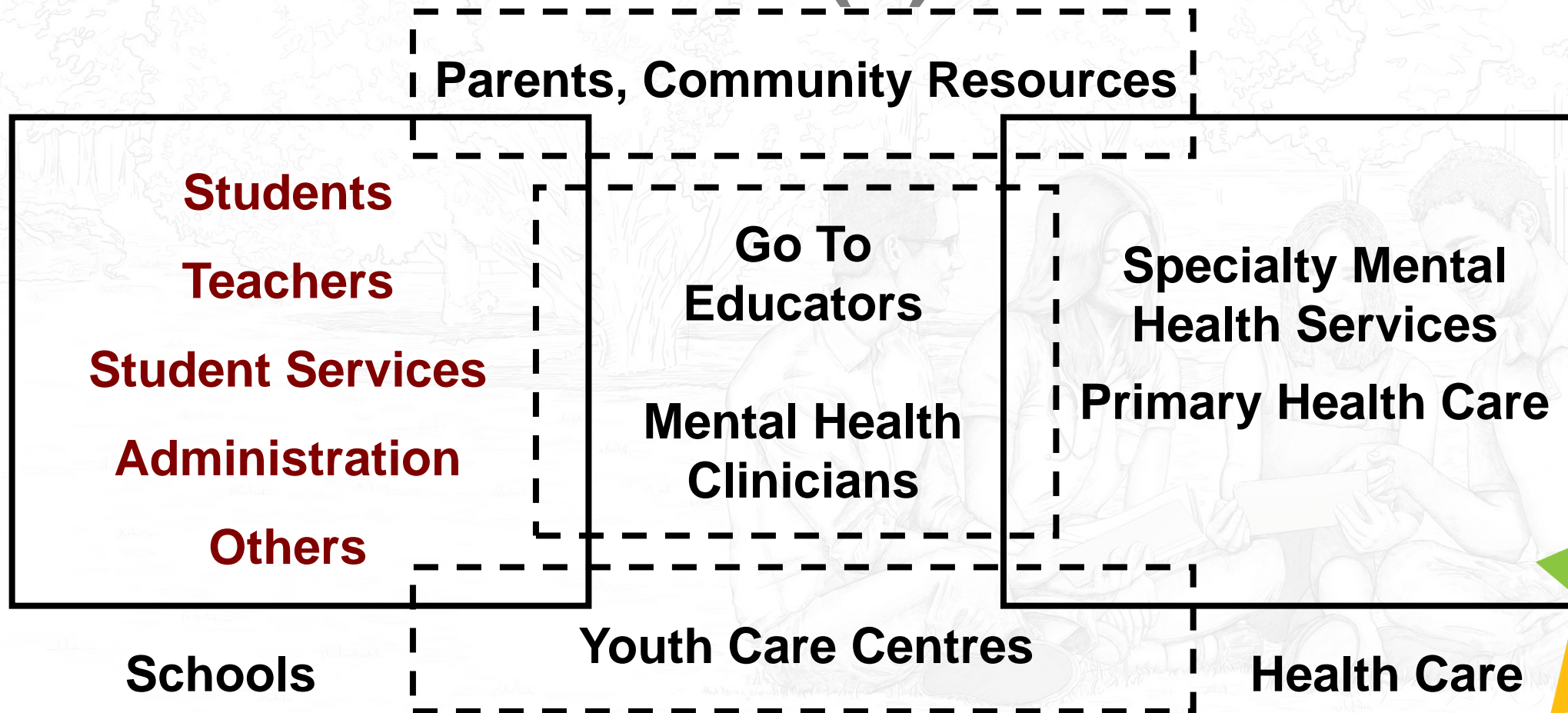
“a stronger predictor of an individual’s health status than income, employment status, education and racial or ethnic group”. WHO; 2013



# Mental Health Literacy: what is it EXACTLY?

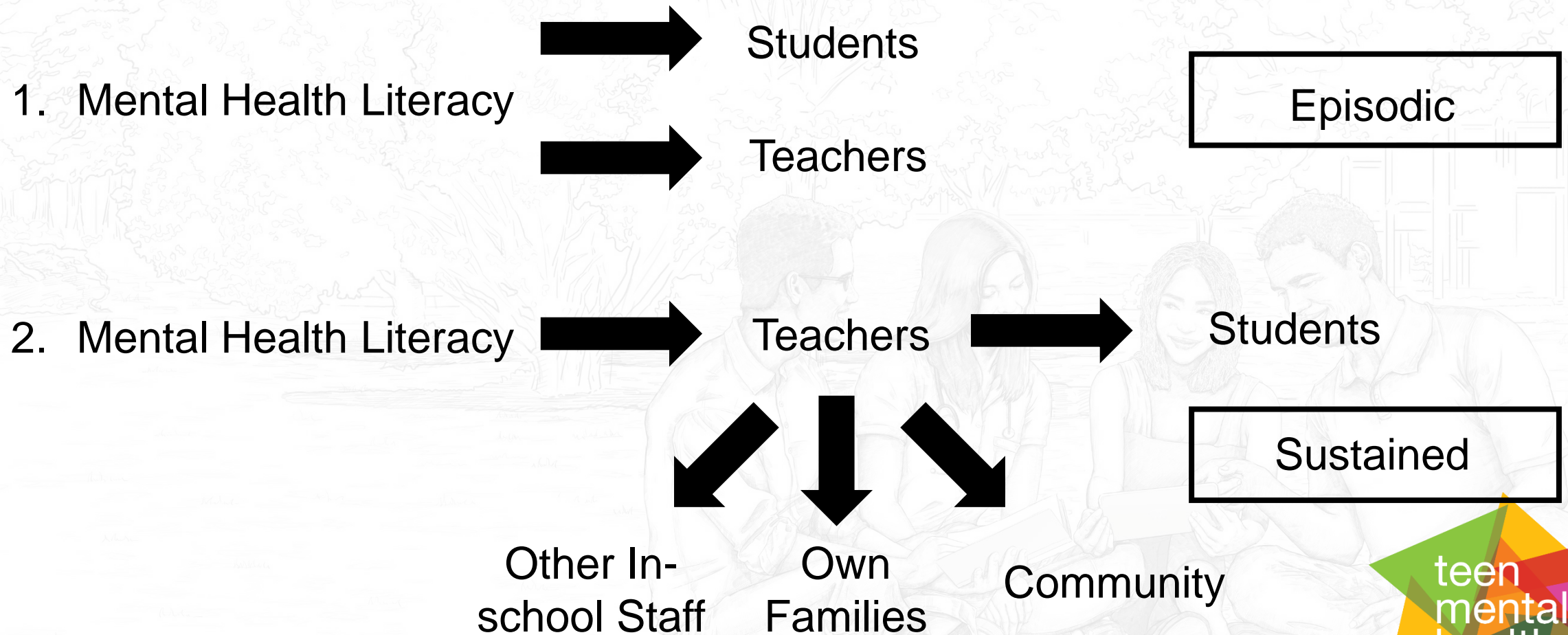
- Understand how to obtain and maintain good mental health
- Understand and identify mental disorders and their treatments
- Decrease stigma
- Enhance help-seeking efficacy: know where to go; know when to go; know what to expect when you get there; know how to increase likelihood of “best available care” (skills and tools)
- Kutcher and Wei; 2014; Kutcher, Bagnell and Wei; 2015: Kutcher et al, in press CJP.

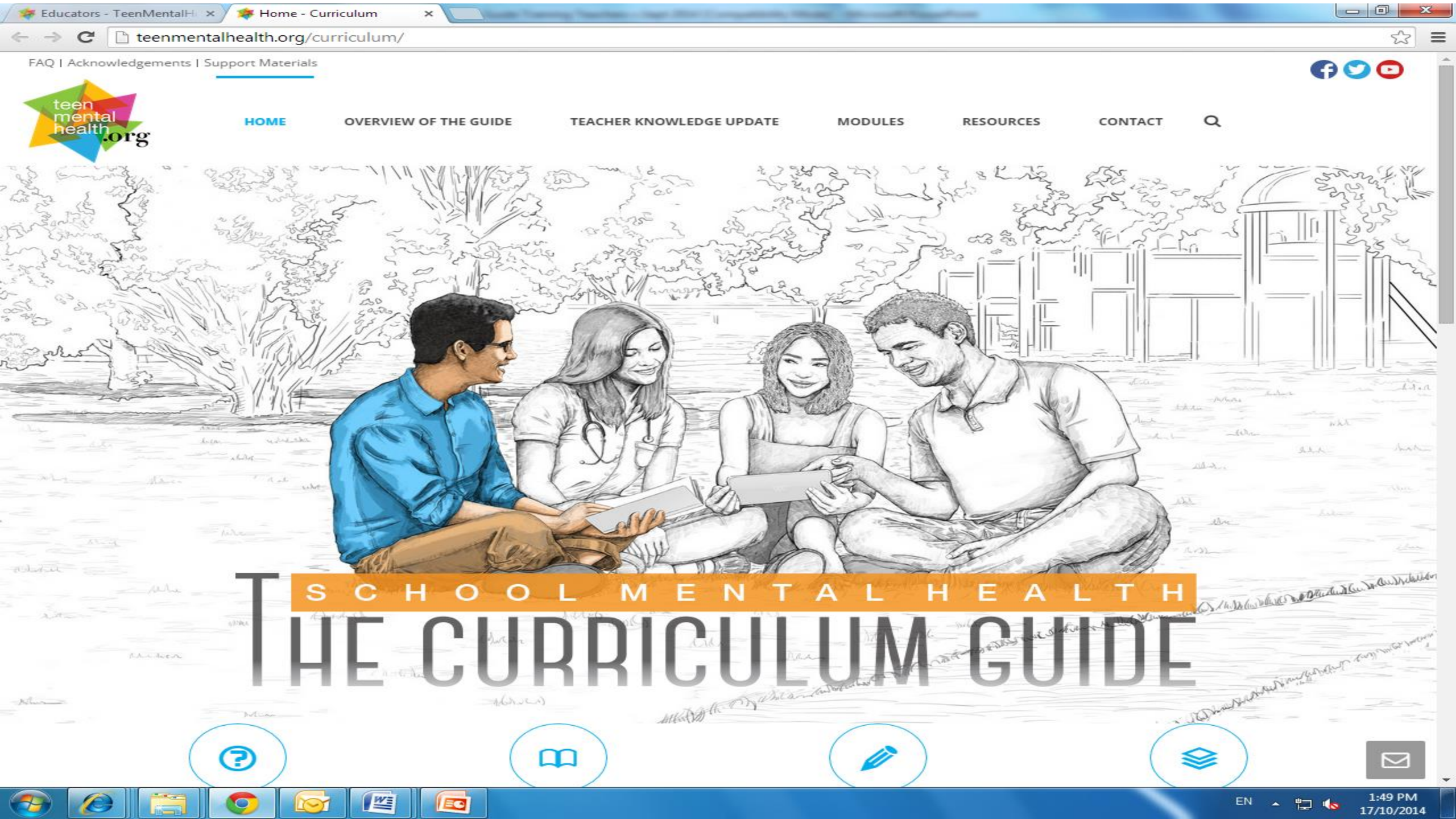
# LINKING EDUCATION & HEALTH CARE SYSTEMS (1)





# SCHOOLS: MHL MODELS (1)





# SCHOOL MENTAL HEALTH THE CURRICULUM GUIDE





# TABLE 1: THE GUIDE OUTCOMES

Province	Study type	Year	Participants	Increased Knowledge		Improved Attitudes		Improved help-seeking	
Nova Scotia	Program evaluation	2012-2013	218 Educators	Yes	p<0.0001, d=1.85	Yes	p<0.0001, d=0.51		
Ontario	RCT	2011-2012	362 Students	Yes	p=0.0001, d=0.46	Yes	p=0.0001, d=0.30	Yes	p=0.01; d=0.18
	Cross-sectional study	2012	409 Students	Yes	p<0.001, d=0.9; p<0.001*, d=0.73*	Yes	p<0.001, d=0.25; p<0.007*, d=0.18*		
	Program evaluation	2013	74 Educators	Yes	p<0.001, d=1.48	Yes	p<0.03, d=1.26		
	Cross-sectional study	2013	175 Students	Yes	p<0.0001, d=1.11; p<0.001*, d=0.91*	Yes	p<0.001, d=0.66; p<0.001*, d=0.52*		
Alberta	Program evaluation	2013	325 Educators	Yes	p<0.0001, d=2.03	Yes?	NS, d=0.21		
British Columbia	Program evaluation	2015	43 Educators	Yes	p<.001, d=2.40	Yes	p=.002, d = .55		
	Cross-sectional study	2015	60 Pre-service teachers	Yes	p<.001, d=2.30; In Progress	Yes	p<.001, d=.90; In Progress		



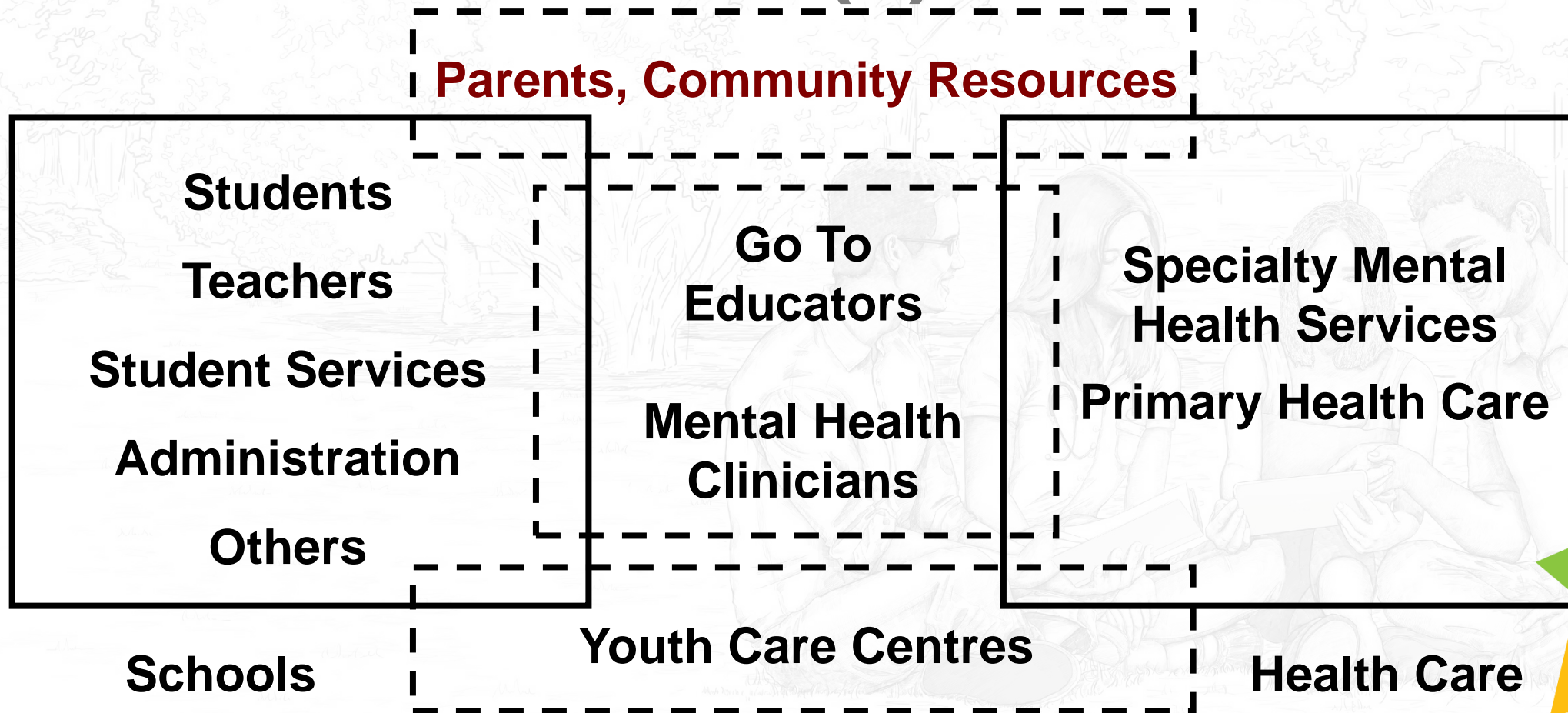


# Hot off the press: BC pre-service teacher trainees (2015); FOE, UBC

Assessment	Change	Pre - Post	Pre – 3 month followup
Knowledge	Increased	P<0.001 d= 3.21	P<0.001 d=2.05
Stigma	Decreased	P<0.001 d=1.09	P<0.001 d=0.68
Help-seeking intent	Increased	N/A	P<0.001 d=0.46



# LINKING EDUCATION & HEALTH CARE SYSTEMS (2)

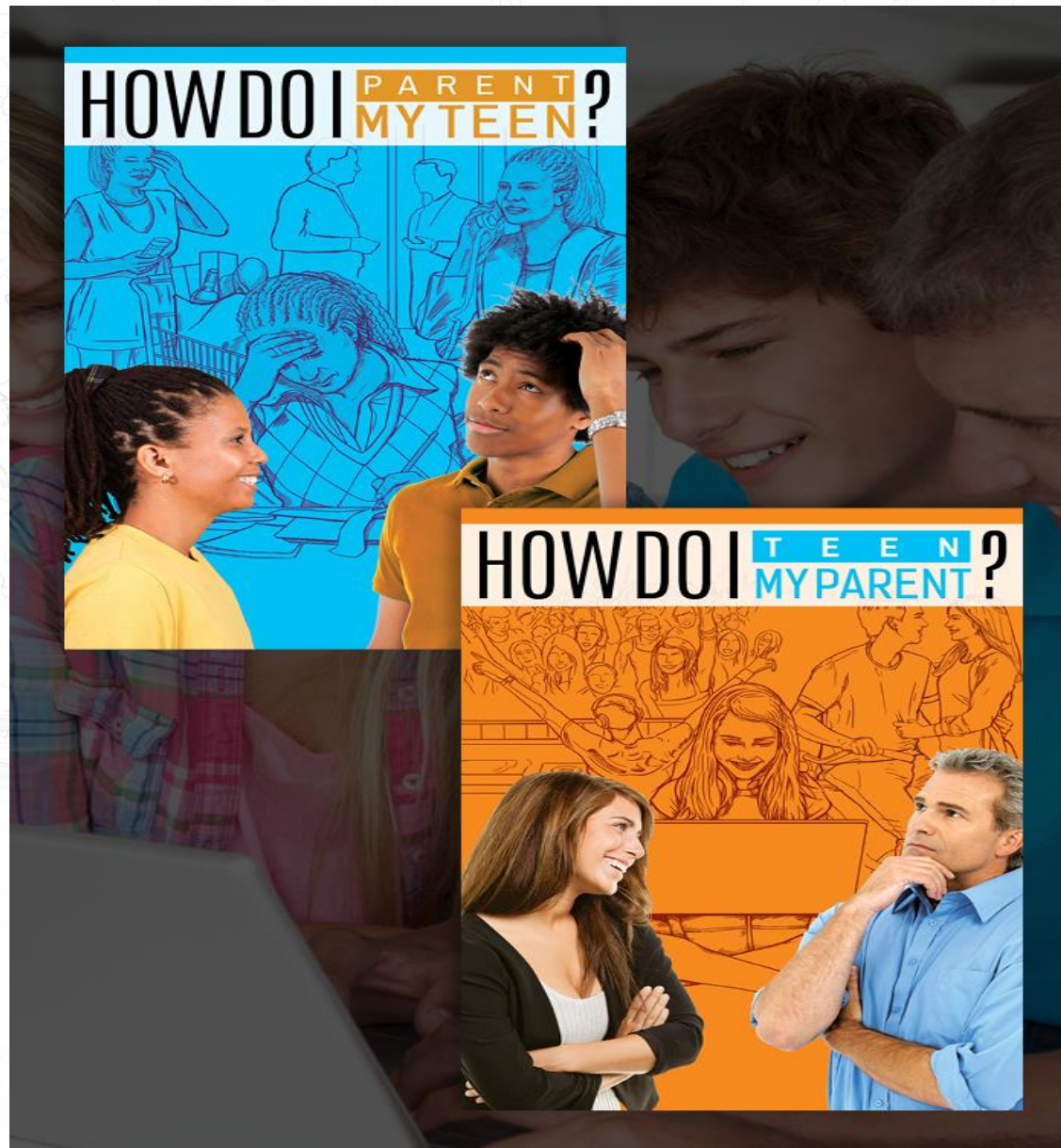


# Engaging the community – through Parents – school HUB

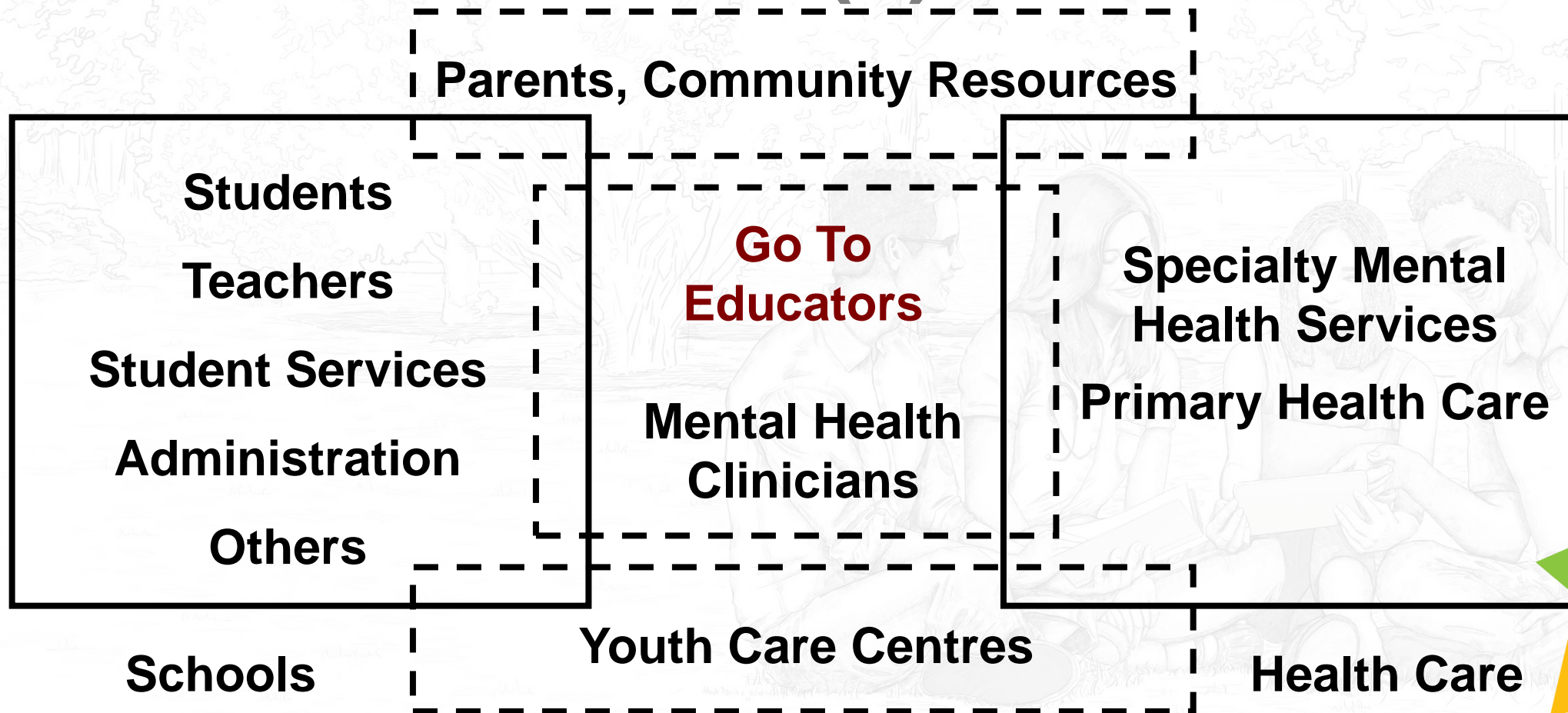
- Very important to engage parents in better understanding of mental health/mental disorders – modified mental health literacy
- Example: Community parent outreach program: Junior High Chats – the Chair Model – physician plus teacher – Junior High Schools
- Example: MENTAL HEALTH BY STEALTH – linking parent education to curriculum mental health literacy classes – How do I Parent my Teen? (companion resource: How do I Teen my Parent?)







# LINKING EDUCATION & HEALTH CARE SYSTEMS (3)





# “Go-To” Educator Training: System Impact

- Brings together: teachers; student services providers; administrators; local community health/mental health care providers
- Creates a common knowledge base with familiarity and application of common evidence based tools
- Clarifies and addresses internal access to care barriers (parental permission example)
- Breaks down historical system silos (common consent form example)
- Improves access to care for those youth requiring specialty mental health services (slight increase in referrals, substantial increase in “appropriate” referrals)

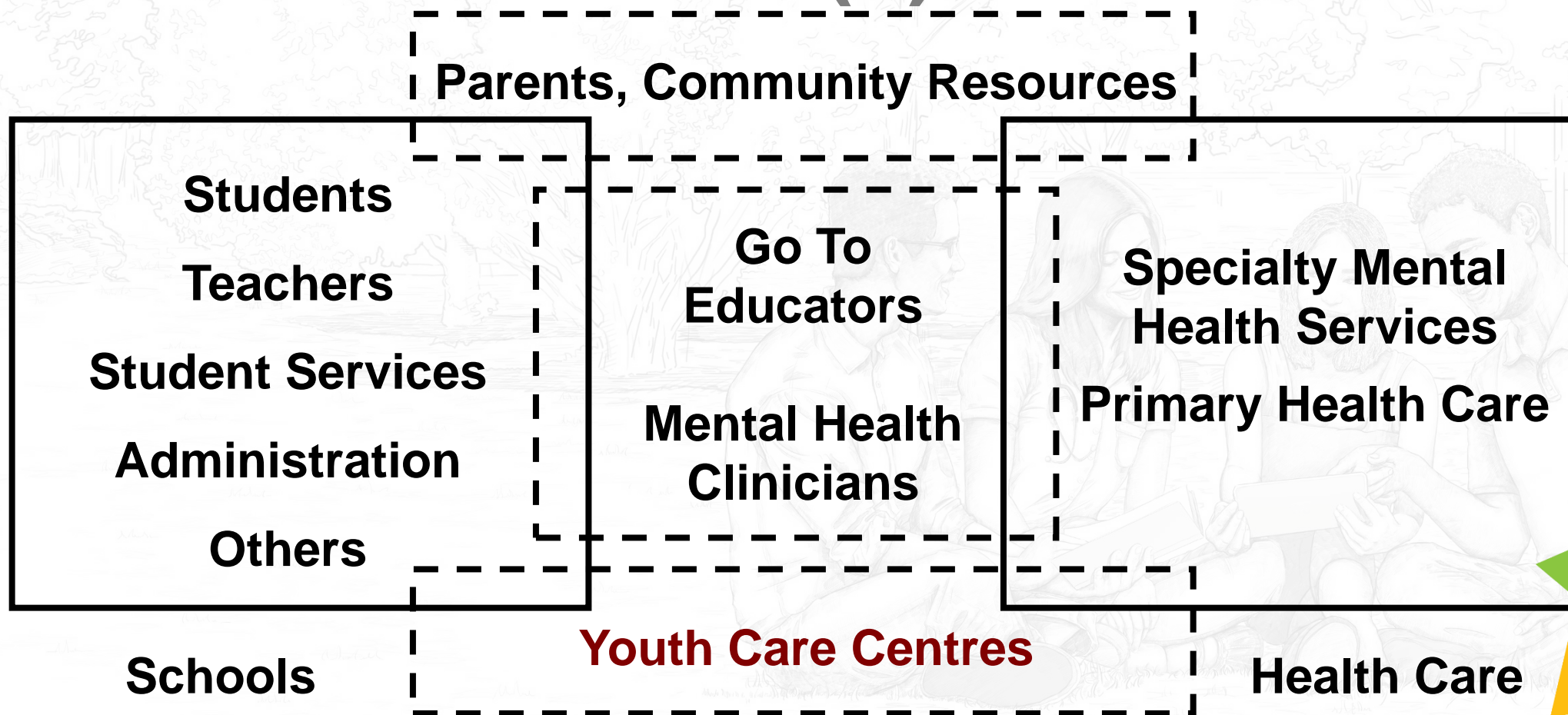
• (SEE: Stephan et al. Child and Youth Services Review. 2013)



# TABLE 2: The “GO-TO” EDUCATOR TRAINING OUTCOMES (ALTA)

Province	Study type	Year	Participants	Increased Knowledge		Improved Attitudes	
Nova Scotia	Program evaluation	2012-2013	120 “Go-to” Educators	Yes	p<0.001, d=2.48	Yes	p≤0.001, d=0.37
Ontario	Program evaluation	2013	244 “Go-to” Educators	Yes	p<0.001, d=1.90	Yes	NS – median analysis VERY ROBUST
Manitoba	Program evaluation	2013	31 “Go-to” Educators*	Yes	p<0.001, d=2.19	Yes	p<0.001, d=0.68
Alberta	Program evaluation	2014	363 “Go-to” educators	Yes	P<0.001, d=2.4	Yes	p<0.001, d=0.19

# LINKING EDUCATION & HEALTH CARE SYSTEMS (4)



# School Based Health Centers (SBHC's): Health for All, Just Down the Hall

- Developed to provide primary health care and prevent teen pregnancy USA (Dryfoos, 1998)
- students can receive integrated (physical/mental) health care in familiar and non-stigmatizing setting
- Can integrate health/mental health promotion with care
- SBHC's provide treatments for physical illness; mental illness and substance use problems – BREAK DOWN SILOS





# School Based Health Centers - value:

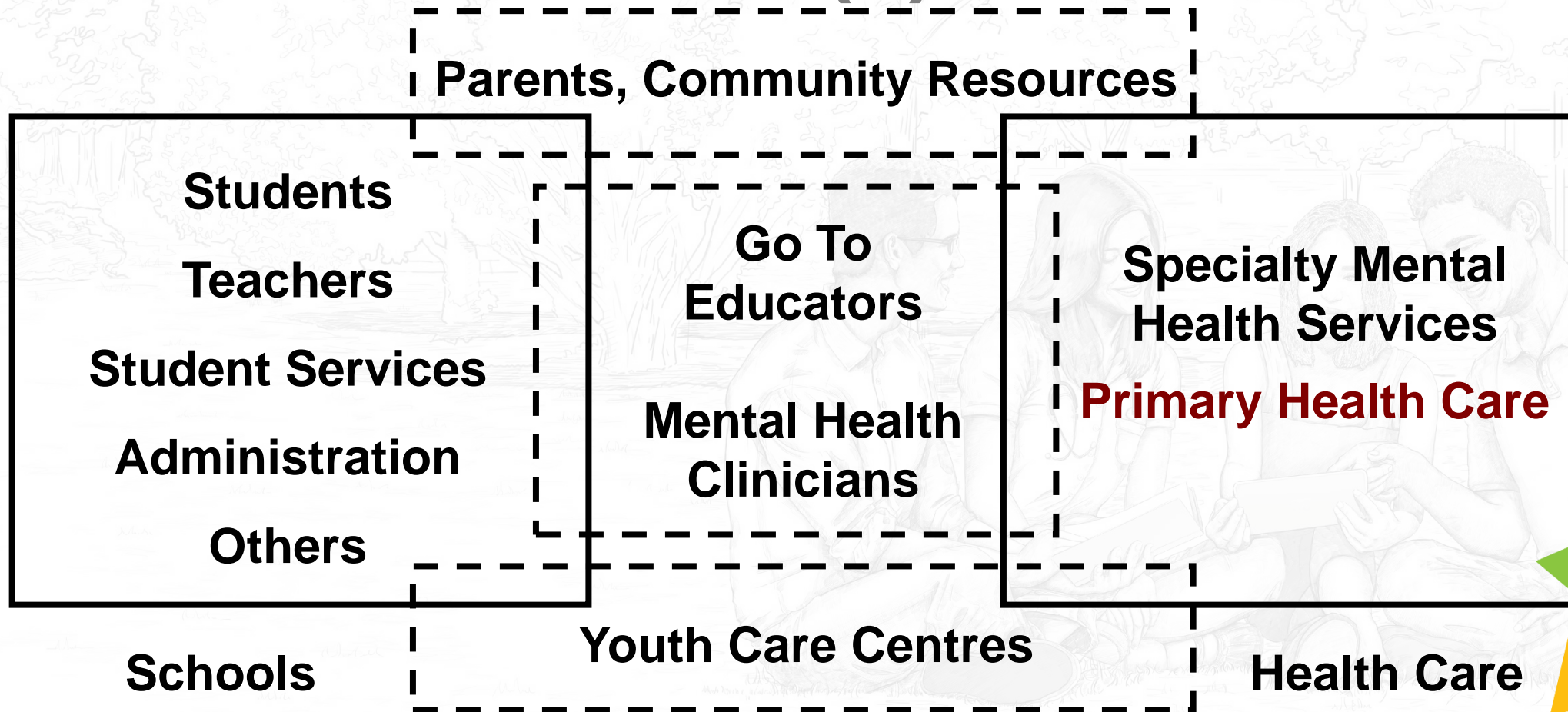
- 1) Enhance access to all types of health care – including MHC – holistic approach – stop the stigma silo
- 2) Able to reach many youth easily/effectively: rural and urban
- 3) Students and parents high satisfaction
- 4) Improved academic performance, decreased absences/behavior problems
- 5) Decreased use of ER services; increased vaccination rates
- 6) Used by “at risk students”: suicidal; mental illness; life-adversity
- 7) Structure and HR competencies important
- 8) Require clear mandate, authority, responsibility – NOT CO-LOCATION

# Counselors roles in school pathway to mental health care (**GOOD VALUE, AVAILABLE**):

- 1) Site for the enhancement of mental health literacy for teachers and students alike (integrated into curriculum; demonstrated effective) – **COUNSELORS AS TRAINERS SUPPORT STAFF TO TEACHERS**
- 2) Site for the identification, triage, referral and support of students who have a mental disorder (“Go To” educators, student services faculty; in-school mental health clinicians) – **COUNSELORS AS TRAINERS AND ON-SITE RESOURCES: ASSESS; TRIAGE; REFER; CO-CARE; SUPPORT**
- 3) Site for the provision of mental health care to young people with low intensity high volume mental disorders – such as mild-moderate Depression; Anxiety Disorders. School Based Health Centers integrate all health care needs on site – easy access to effective care – **COUNSELORS AS CARE PROVIDERS**
- 4) Sites for the engagement of community – through parents: eg: Junior High Chats and the promotion of mental health by stealth (Parenting my Teen): **COUNSELORS AS COMMUNITY EDUCATORS**



# LINKING EDUCATION & HEALTH CARE SYSTEMS (5)



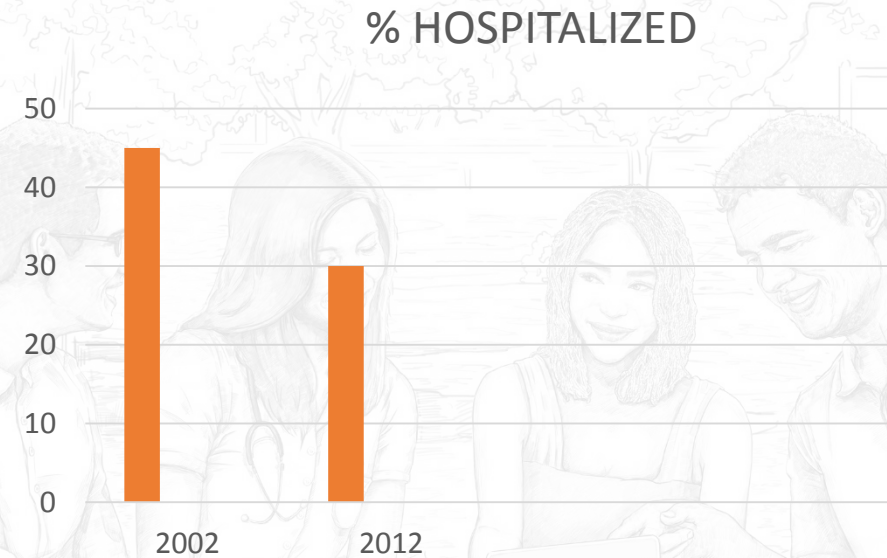
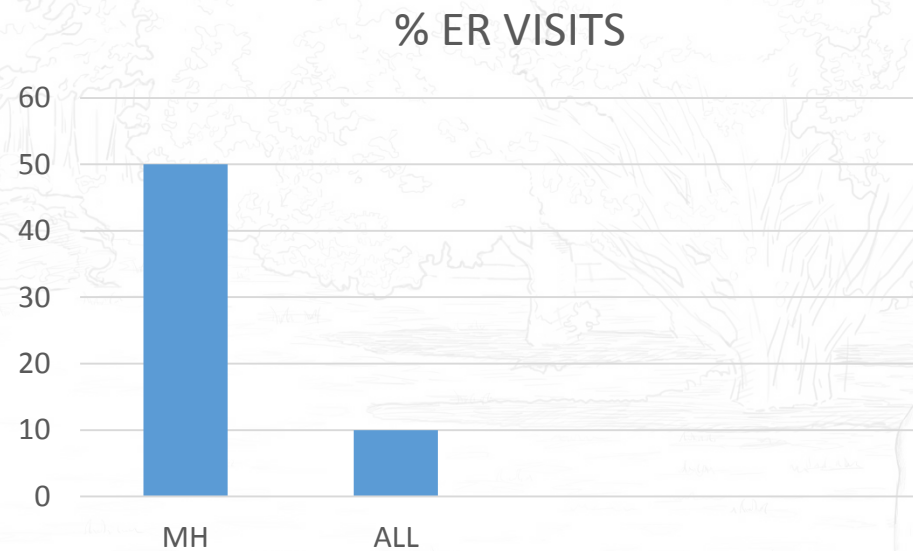


# YOUTH MENTAL HEALTH CARE IN PRIMARY CARE

- 1) Most mental disorders can be diagnosed prior to age 25 years – FAMILIAL
- 2) Many mental disorders are mild to moderate in intensity at onset – respond well to Rx
- 3) Negative outcomes of mental disorders often dependent on Duration of Untreated Illness (DUI) and delayed application of best evidence based care
- 4) Availability of effective mental health interventions that can be provided in primary health care settings: effectively, efficiently
- 5) Primary care health providers ideally positioned for: risk assessment; early identification; early effective treatments – THE FAMILY HEALTH CARE HOME
- 6) Requires some minor modifications in how primary care settings usually deliver care (availability of psychotherapies)
- 7) Requires an appropriately trained primary health care workforce
- 8) Alma-Ata, 1978; WHO/WONCA, 2008; CFPC, 2011
- 9) Canadian primary care providers report challenges in addressing needs



# ER YOUTH MENTAL HEALTH USE: BC 2002-2012



(Mapelli et al. J. Pediatrics. Aug. 2015)





# Canadian GP's and youth mental health: MOST YOUTH MHC ALREADY IN PRIMARY CARE!

- Steele (2012) low confidence, low skills but high numbers of cases: most report need for more training
- Miller (2005) need for more training; when received training comfort and skills improved; higher levels of comfort/skills related to lower referral rates to specialty mental health service
- Maheux (2006) 53% of primary care physicians in private practice felt “adequately informed” about mental health services available in the community







A GPSC Initiative

# PSP Child and Youth Mental Health

British Columbia Medical Association in collaboration with the Sun Life  
Financial Chair in Adolescent Mental Health

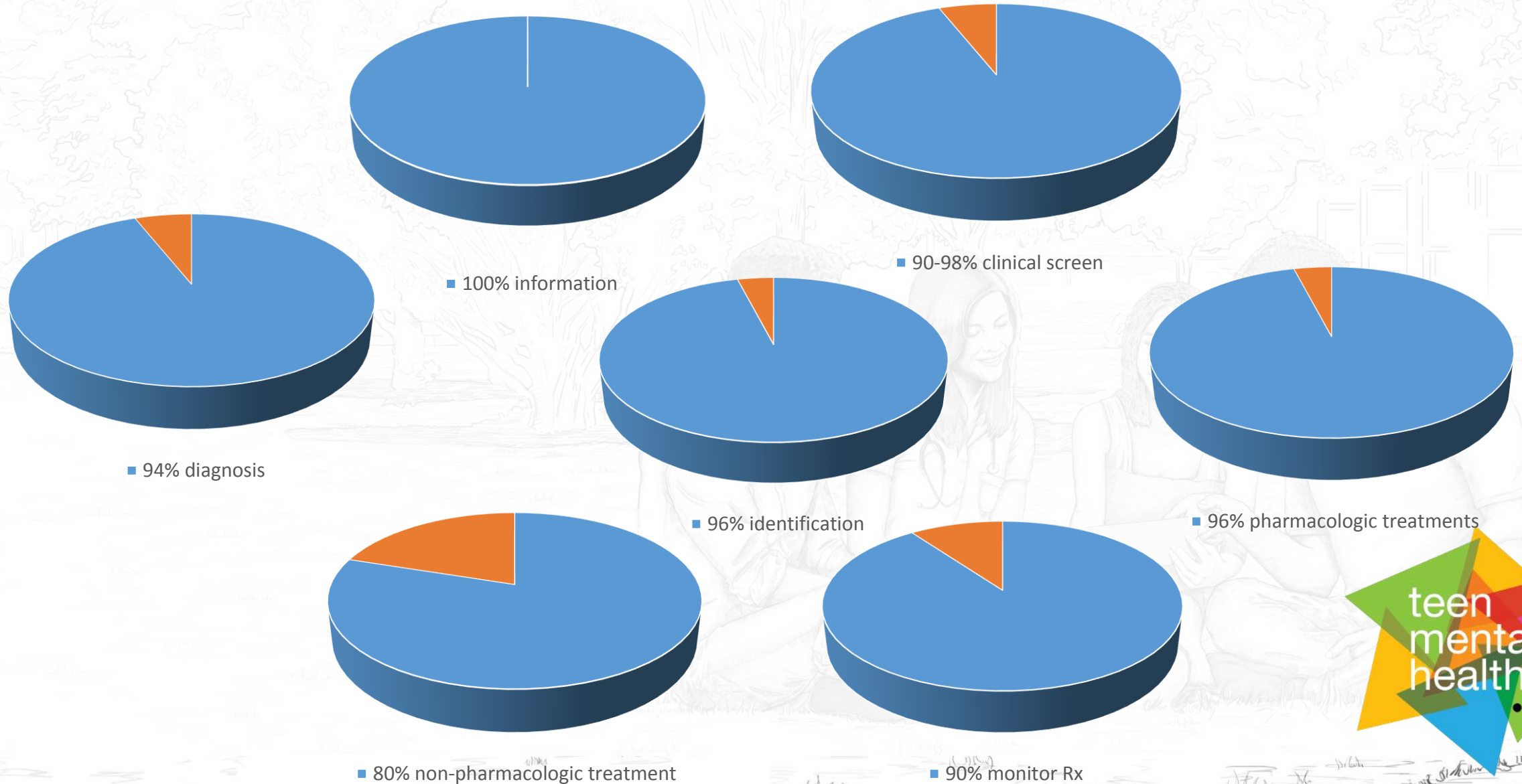


General Practice Services Committee

# LOCAL TEAMS

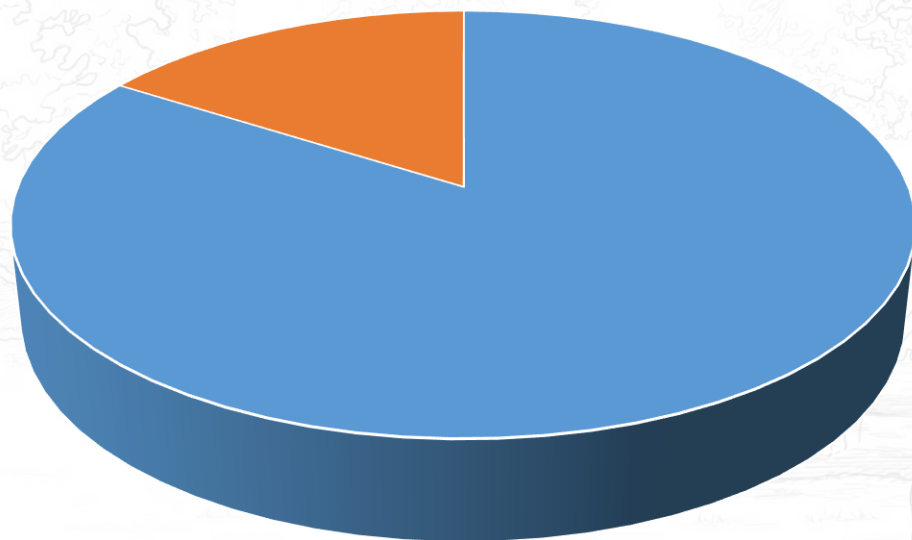


# CASE COMPETENCY CONFIDENCE

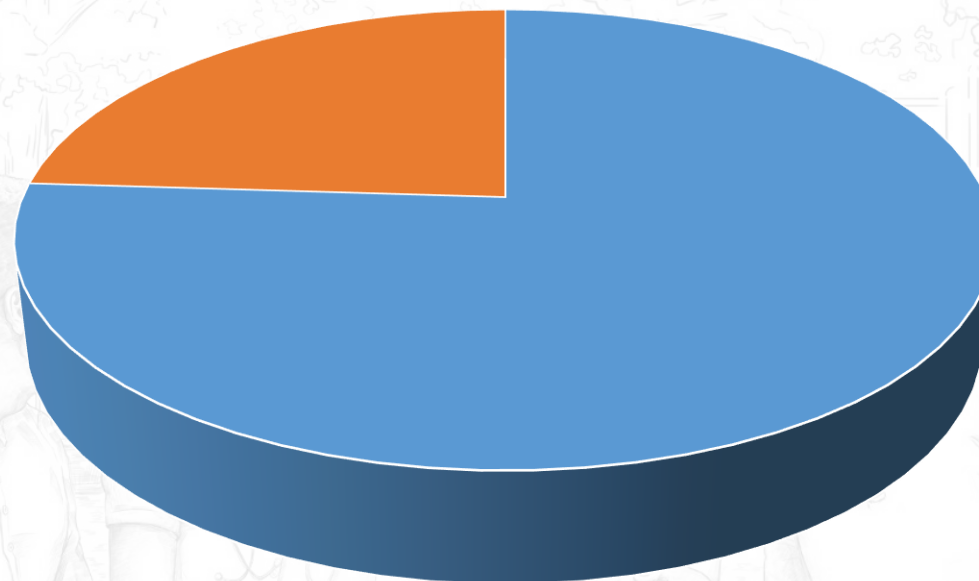




# IMPACT OF TRAINING ON GP CHILD AND YOUTH MENTAL HEALTH COMPETENCIES (PSP)



■ 84% improved school collaboration



■ 76% improved mh collaboration



# Executive Primary Care: Core

Competencies for Primary Care Health Providers in Four Common Youth Mental Disorders – (February 2012v.)

**Professor. Stan Kutcher**

**Sun Life Financial Chair in Adolescent Mental Health &  
Director, WHO Collaborating Center, Dalhousie University**

**Funding and support provided by**



Kathryn A.  
Weldon  
Charitable  
Foundation

**Referrals by Primary  
Care Physicians to  
the mood and  
anxiety clinic  
decreased by 31%**

*while simultaneously...*

**Referrals to the urgent  
consult clinic changed  
from common non-  
comorbid disorders to  
complex moderate to  
high comorbidities**





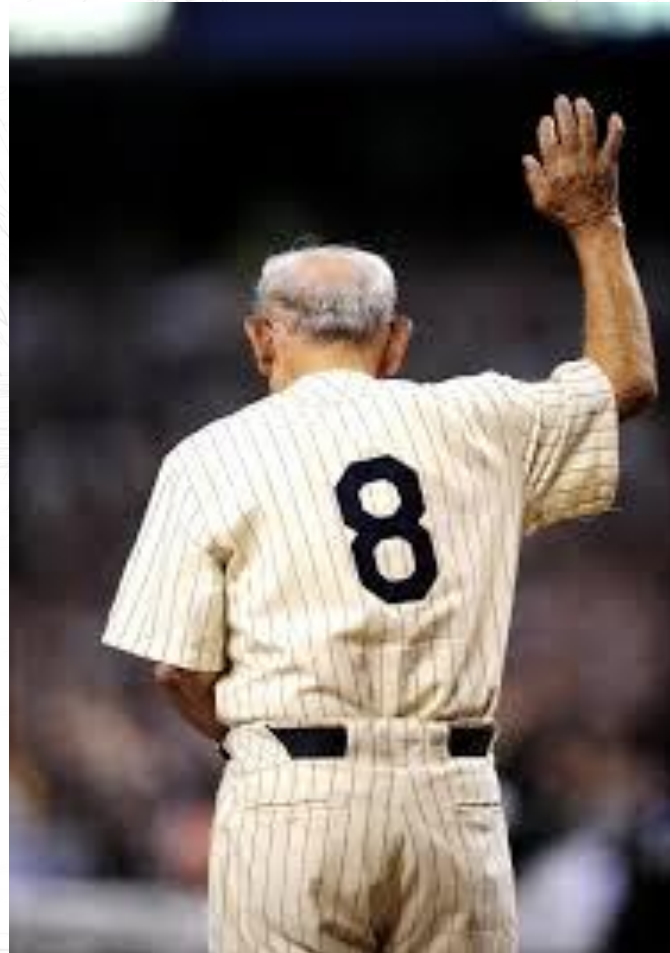
# TRANSFORMATION IS POSSIBLE NOW:

- 1) Enhance mental health literacy in the school setting – curriculum resource for BOTH teachers and students (train pre-service teachers)
- 2) Use school as community HUB to engage parents and local youth serving services
- 3) Embed capacity for early identification, triage, referral and support into school systems – “Go To” Training
- 4) Create and properly deploy School Based Health Centers
- 5) Enhance capacity for rapid equitable access to effective care in the primary health care setting – FAMILY HEALTH CARE HOME



# YOGI BERA-ism

## IT AIN'T OVER TILL ITS OVER







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