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# Healthy Transitions to Adulthood: Moving to Integrated Mental Health Care

## Workshop Report

November

**PRI Project**
**Engaging US Think Tanks**

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Canada

Each year, the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO invites talented youth to use their creativity to produce an enduring image of child and youth mental health. The image on the front of this report is the product of the Centre's 2008 mural project, entitled Overcome.

YOUR WORLD

A single thought can blossom into a beautiful world.
Break down the boundaries of your mind . . . let it grow.
Tear down the wall that traps your thoughts . . . let it grow.
Unleash yourself and awaken cloudy memories of the past . . . let it grow.
Grab hold of your dream . . . let it grow.
Think openly and your world will grow.

The Centre's mural project is supported by staff and volunteers at the Ottawa School of Art. Thanks go to them and the remarkable youth who created Overcome:

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## *Foreword*

In Canada, policy research occurs mainly inside government and at universities. In the United States, think-tanks play a much larger role in research and in influencing the public policy agenda. Initiated in 2007, at the request of the Clerk of the Privy Council, the goal of the Engaging US Think-Tanks Initiative was to improve the dialogue between the scholarly and policy communities in the United States and Canada at the early stages of policy development and to offset growing social pressures to provide short-term "solutions" to complex problems.

The Policy Research Initiative (PRI), with selected federal departments and Canadian universities, acts as a secretariat to the Engaging US Think-Tanks Initiative. In doing so, the PRI supports workshops to advance research on issues that have important public policy implications and strengthen the collaboration between Canadian and US think-tanks, academics, and policy makers around the medium-term policy agenda. Workshops are designed to consider matters at the science-policy interface with the goal of informing forward-looking, research-based policy development. The initiative is co-chaired by Dr. Heather Munroe-Blum, Principal and Vice-Chancellor of McGill University and Dr. Howard Alper, Distinguished Professor at the University of Ottawa and Chair of the Government of Canada's Science, Technology and Innovation Council.

As pilot events, the PRI organized working sessions in June and September 2007 to explore potential topics and their relevance to Canadian and US policy makers and scholars. The first workshop focused on water, an emerging public policy issue, with unique implications for both nations. On October 2, 2007, the Woodrow Wilson International Center for Scholars[1] hosted a workshop in Washington, DC, to explore possible areas and means of improving Canada-US policy research links in freshwater policy in the context of water and climate change and the energy-water nexus. The report was released in the winter of 2008.

The current report summarizes the presentations and dialogue that occurred on the second theme explored in this series: youth mental health and healthy transitions to adulthood. The workshop was again hosted by our partners at the Woodrow Wilson Center, drawing a mix of speakers and participants who specialized in youth research, policy making, and service provision. The event was held on November 3, 2008.

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## *Executive Summary*

Mental illness is the most prominent health issue for youth, affecting about 15 to 25 percent of young people as they transition to adulthood. New research relating to brain and social development and the intersections of mental health with other determinants, as well as improvements in mental health treatment are causing policy makers in Canada, the United States, and elsewhere to re-examine existing policies and programs. For this reason, the Policy Research Initiative (PRI) invited over 30 Canadian and US researchers, policy makers, service providers, and people who used mental health services in their youth to participate in a workshop – Healthy Transitions to Adulthood: Moving to Integrated Mental Health Care – held in Washington, DC on November 3, 2008. A leading Australian researcher also participated, adding valuable perspective as best practices emerged in the discussions. The purpose was to explore three principal themes on youth mental health and healthy transitions to adulthood: recovery and resilience, the intersections between mental health and the determinants of health, and systems of care to address the particular policy/program challenges for youth with mental health issues as they "age out" of the children's service system.

Throughout the workshop, participants discussed the ways in which the years leading up to adulthood mark a unique developmental window. In this period, social transitions (into post-secondary education, employment, marriage, parenthood, or other new situations) and biological development interact and influence each other. While there is broad capacity for transformations in youth, through new social and career opportunities, recent findings in neuroscience show that it is also a critical formative period in which brain structure and function can be shaped by favourable or adverse experiences.

Participants identified ways in which policies and programs for youth could be improved, given the current knowledge and emerging scientific research.

***Collaborate to raise awareness, inform policies, and reduce stigma by addressing the myths and misconceptions that give rise to it.***
Collaborative efforts in Canada, the United States, and elsewhere could increase public awareness and reduce the discrimination that still exists against people with mental illnesses. The myths and misconceptions that give rise to stigma create barriers to care for young people and their families, and limit their ability to become active participants in their communities and the work force. As an early result of the workshop, some concrete joint actions have already taken place, including Canada-US collaboration around the 2009 Children's Mental Health Awareness Day.

***Recognize the central role of youth and families in research, policy, and program/service development and delivery, including in governance structures.***
Young people and families from diverse cultural communities and of differing socio-economic backgrounds need to be involved in all aspects of mental health service provision, from the research design, to policy development, and program

and service delivery. Involvement in these processes can increase the resilience of youth and positively influence mental health outcomes.

***Integrate mental health services with the overall health system and with other youth service systems (justice/education/foster care, etc.).***
In Canada, the United States, and elsewhere, a co-ordinated and integrated system of care is required to better assist youth facing mental health issues. Efficiencies could be gained by integrating mental health services within existing primary health care services. Shortages in the number of mental health care providers could be addressed by fully involving sectors, such as employment, housing, justice, and welfare.

***Consider needed supports for young people as a constructive lens to address research, policy, and programs.***
The needed supports (also known as scaffolding) can be provided by putting appropriate policies into place that support youth who experience particular risks, as well as their families. Early intervention and supports are needed for youth experiencing the onset of a mental illness, and prolonged supports are required for youth living in poverty or transitioning out of foster care.

***Develop appropriate responses to meet the mental health needs of Indigenous populations and other cultural groups.***
There is a need to understand the strengths and specific supports provided in different cultural communities and to understand where weaknesses lie in order to develop targeted, culturally appropriate interventions and treatment.

***Collect comparable data across countries by collaborating in a longitudinal cohort study.***
Roundtable participants observed that in Canada and the United States, significant gaps in the evidence base still exist. Longitudinal cohort data on youth mental health are critical to show long-term results of interventions and to further identify the benefits of early prevention and treatment of mental illness.

***Share knowledge about research, policy, and program experience and challenges.***
Moving the best practices and information from academics and researchers to the service provider is critical. Benefits could be gained by identifying and sharing best practices internationally.

Roundtable participants recognized that youth mental health is an issue where policy makers have much to benefit from emerging scientific research findings. Participants emphasized that in Canada, the United States, and elsewhere, there is a need and an opportunity for policy attention.

## *Introduction*

Mental illness is the single most prominent health issue for youth in their adolescence and early 20s,[2] and it can have devastating effects if left untreated. It is estimated that 80 percent of adults suffering from a psychiatric disorder can trace the earliest manifestations of their illness to a relatively discrete time between the ages of 15 and 24 (Health Canada, 2002). Schizophrenia often emerges in this age bracket; anxiety disorders are more common; and suicide accounts for 24 percent of youth mortality in Canada (Health Canada, 2002). In some sectors of the population, these rates are even more acute. Suicide rates are estimated to be five to seven times higher for First Nations youth and 11 times the Canadian average for Inuit, placing their risk among the highest in the world. Poor mental health is strongly related to other health and development concerns: it can affect educational achievement, occupational or career opportunities and successes, and the formation and nature of personal relationships. The impacts of mental illness can extend throughout an individual's life, with ripple effects on the family, workplace, and community.

New findings on brain development during adolescence and early adulthood combined with emerging research on the effectiveness of treatment at the onset of mental disorders indicate that policy makers can benefit from emerging scientific research findings. In Canada, the United States, and elsewhere,[3] governments recognize the need and opportunity for policy attention. Youth mental health was therefore seen as an appropriate theme for exploration through the Engaging US Think-Tanks Initiative, because it provided an opportunity to explore an issue relevant to both the United States and Canada for the medium-term policy agenda, where both countries could benefit from an exchange of emerging research findings.

## *The Workshop*

On November 3, 2008, the PRI invited Canadian and US academics, policy makers, and service providers to the Woodrow Wilson International Center for Scholars in Washington DC to explore three principal themes on youth[4] mental health and healthy transitions to adulthood:

- recovery and resilience;
- the intersections between mental health and the determinants of health; and
- systems of care to address the particular policy/program challenges for youth with mental health issues as they “age out” of the children’s service system.

The workshop began with an overview of the policy landscape on youth and mental health issues in Canada and the United States, provided by the Honourable Michael Kirby, Chair of the Mental Health Commission of Canada and Dr. Gary

Blau, Chief of the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States. Following this introduction to the topic, organizers asked three panellists to present on each theme to stimulate discussion. Participants and panellists were selected based on their experience and expertise on mental health research, policy development, and treatment in Canada, the United States, and Australia.

To open the first panel on recovery and resilience, Judy Finlay, former Chief Advocate of the Office of Child and Family Service Advocacy in Ontario and current associate professor at Ryerson University, discussed the tensions between children/youth and the environment in which they are raised, and she shared her observations of resilience in some Indigenous[5] communities in Canada. Dr. Ann Masten of the Institute of Child Development, University of Minnesota, followed this presentation and discussed patterns of resilience. She described the period of youth as a unique developmental stage when social and environmental factors interact with genetics and development, pointing to the importance of providing appropriate supports to youth at risk. Andy Cox, the Mental Health Patient Advocate for Children and Youth at the IWK Health Centre (Halifax) and member of the Board of Directors, Mental Health Commission of Canada, continued on this theme, describing his first-hand experience with the mental health system and his personal journey of resilience and recovery.

The second theme explored the determinants of mental health. Dr. Stanley Kutcher, Director of the WHO Collaborating Centre in Mental Health Training and Policy Development, Sun Life Financial Chair in Adolescent Mental Health of Dalhousie University began by discussing how socio-environmental factors influence brain development. Dr. Ronald Dahl, Staunton Professor, Pediatrics and Psychiatry, University of Pittsburgh continued by exploring the intersections between brain development and emotionally motivated behaviour in youth. This section of the agenda was punctuated by the first-hand observations of youth in care, as described by Mr. Bernard Richard, New Brunswick Ombudsman and Youth Advocate.

The final theme addressed systems of care. Dr. Patrick McGorry of the University of Melbourne, Australia led the panel by describing the importance of examining the burden of mental disorders for youth and the fact that most adult disorders have their peak rates of incidence during the transition to adulthood. He effectively made the case that the mental health care system is weakest where it needs to be strongest and he described Australian best practices in youth treatment. Dr. Simon Davidson, Chief of Psychiatry and Medical Director Mental Health Patient Services Unit, Children's Hospital of Eastern Ontario, followed this presentation by discussing the state of mental health care in Canada, the recently established Mental Health Commission of Canada and the benefits that could be gained through a co-ordinated continuum of care for youth, ranging from wellness promotion and mental illness prevention through risk reduction and coping enhancement. Dr. Hewitt B. ("Rusty") Clark of the University of South Florida was

the final speaker of the day, describing an evidence-supported practice implemented by the National Center on Youth Transition and Behavioral Health, called the Transition to Independence Process (TIP) system.

## *Key Messages*

A 30-minute discussion followed each thematic panel. The following key messages emerged across the themes repeatedly throughout the day.

1. Collaborate to raise awareness, inform policies, and reduce stigma by addressing the myths and misconceptions that give rise to it.
2. Recognize the central role of youth and families in research, policy, and program/service development and delivery, including in governance structures.
3. Integrate mental health services with the overall health system and with other youth service systems (justice/education/foster care, etc.).
4. Consider needed supports (or scaffolding[6]) for young people as a constructive lens to address research, policy, and programs.
5. Develop appropriate responses to meet the mental health needs of Indigenous populations and other cultural groups.
6. Collect comparable data across countries by collaborating in a longitudinal cohort study.
7. Share knowledge about research, policy and program experience, and challenges.

The workshop provided a chance to explore opportunities for collaborative projects and advance our understanding of sound public policy, consistent with scientific evidence on youth mental health and development. The specific aims of the day were to seek opportunities to strengthen the research by leveraging the work being done in the United States, Canada, and elsewhere to inform the medium-term policy agenda. Hearing the experiences of Australia added a valuable perspective as best practices emerged in the discussions. From the outset, participants consistently wanted to advance the research and policy agendas through action. There was an early focus on identifying opportunities that would make a difference in the iterative cycle of research-policy-practice-outcomes (see Annex 3 for a detailed list of action items identified at the Tour de Table). At the time of printing, some concrete joint actions had already taken place, including Canada-US collaboration around the 2009 Children's Mental Health Awareness Day.

This report reflects the presentations and discussions that took place on November 3, 2008, beginning with an overview of youth mental health prevalence, research, and policies in Canada, the United States, and Australia. Following this introduction to the topic and key policy challenges, we examine environmental and social factors influencing brain development and mental health at this phase of the lifecourse. Then, we take a closer look at youth as a period characterized by vulnerability, risk, and resilience. Finally, we examine the system of care available

for treating youth suffering from mental illness. Throughout the roundtable discussion and this report, two complementary ideas intertwine: the unique developmental characteristics of this phase of the lifecourse, and youth as a period when there is an epidemiological onset of mental disorders.

## 2. Setting the Stage

### Transitions to Adulthood: The Policy Challenge

Studies show that today's youth are more likely to delay and "boomerang" through the transition to adulthood. The majority of young people in Canada and the United States are postponing major markers of adulthood – living on their own, completing education, achieving economic independence, choosing a life partner, and having children. Where the transition to employment used to take about six years to complete (1990), it is now taking eight. In Canada, studies show that by age 23, slightly over half (54%) of young people are employed and no longer in school. Not only is the transition to adulthood taking longer, but it has also become increasingly complex as youth carve out new, uncharted paths for learning, working, and living.

For some young people, the transition to adulthood can be a time of increased anxiety, stress, and the onset of severe mental illness. Critical mental disorders, such as schizophrenia, and serious mood disorders are generally manifested for the first time among people 15-24 years of age. Suicide accounts for nearly a quarter of all deaths in this age group (Health Canada, 2002). Although rates of mental illness in youth are consistent in Canada, the United States, and Australia, they can be more acute in some sectors of the population. For example, suicide rates are significantly higher for Indigenous youth in Canada. The burden of disease is considerable: poor mental health is a leading cause of disability for people in their transitional years and decades of unrealized potential and disability can result, if the illness is left untreated (McGorry et al., 2007).

In Canada in 1961, only eight percent of 20-24 year olds attended a post-secondary educational institution. This increased to 42 percent by 1991 and to 48.5 percent by 2001; In the United States, between 1970 and 2004, post-secondary enrollment rose from 22 to 35 percent for youth aged 20-24.

Young people in Canada live with their parents for longer periods: 50 percent of 24 year old men and 22.5 year old women still lived with their parents in 2001. Roughly one third returned home at least once after an initial departure. In the United States, slightly more than half of men and nearly two thirds of women had left their parents' home by age 22; one sixth of both returned home at some point before age 35.

The median age of the first marriage rose from 21 years for women and 23 years for men in the early 1970s in both the United States and Canada, to median ages of 26 (US women) and 27 (US men); and 28 (Canadian women) and 30 (Canadian men) respectively for those marrying at the turn of the new millennium. The average age of women at first birth increased from about 23 in 1976 to 28 by 2003. In the United States, the average age was 25 in 2002, up from 21.4 years in 1970.

The care available to youth with mental illnesses in Canada and the United States is often perceived as complex, difficult to access, and ill-suited to the needs in this age group. The mental health care system is modelled on pediatric and adult health care models, despite the fact that mental health follows a different pattern of peak onset and burden of disease. Adolescent mental health is typically embedded within child-oriented service settings and is curtailed in the mid to late

teens while adult mental health services focus on late-stage disease in mid-life (McGorry et al., 2007). Youth are at a transitional time in their lives (both socially and biologically), and evidence shows that they are too old for child mental health services, yet too young to be effectively treated in adult systems of care.

Added to this is the fact that the stigma about mental health issues presents a significant barrier for youth and their family members. "In Canada, 38% of parents said they wouldn't tell anyone if their child had a mental illness. Moreover, 75% of youth said they wouldn't talk about a mental health issue with their doctor."[7] These facts point to one of the most damaging results of stigmatization: affected individuals and their families may not seek treatment, hoping to avoid the negative social consequences of diagnosis. Stigmatization of people with mental disorders can also reduce patients' access to socio-economic resources and opportunities (e.g., housing, jobs) and lead to low self-esteem, isolation, and hopelessness. It can deprive people of their dignity and interfere with their full participation in society (WHO, 2001). Fighting stigma is therefore seen as being an important step toward improving social inclusion of youth suffering from mental illness and also for ensuring that youth receive early treatment for their disorders.

## *Overview of Current Mental Health Policies in Canada, the US and Australia*

In Canada, the United States, and elsewhere, youth in the transition age are considered to be an underserviced sector of the population. Public policies for this age group are often inconsistent: youth-related legislation tends to be highly specialized according to sector (e.g., education, employment, justice, and health), and youth programs often have different age parameters.

### *Mental Health in Canada*

There are considerable variations in governance, legislation, and services across Canada. The funding and delivery of mental health services and supports are primarily the responsibility of provincial and territorial governments, and each province/territory has its own mental health policy and legislation. It is little surprise therefore that the age of consent to treatment varies from not being dictated by statute at all in Newfoundland and Labrador, up to the age of 19 in Yukon.

While most provinces do not have mental health programs specifically targeted to youth, two provinces have published frameworks for action targeting young people in the transition age: The Alberta 10-year strategy supports a common and integrated approach to optimizing the mental health of children and youth up to age 24. It is aligned with the provincial mental health plan and other strategic provincial initiatives. Quebec also has a mental health action plan (2005-2010) that includes specific actions targeted to youth, including the transition years, up to age 25.[8]

In all provinces except Ontario,[9] health ministries divest authority for direct service delivery to the regional health authorities, which function within local geographical areas. Provincial mental health services are also available from formal health services providers (primary care, general hospital care, and psychiatric hospitals) and informal services provided by community organizations, non-governmental organizations, and consumer-run organizations. In some provinces, there is more than one ministry responsible for child and youth mental health. In Ontario for example, while the Ministry of Health and Long-Term Care is responsible for many mental health programs, those specifically targeting youth (up to age 18) are funded by the provincial Ministry of Children and Youth Services (2009). Other social services and programs that may have an influence on youth mental health (community services, family supports, sports and leisure activities, etc.) are spread across multiple departments. The issue becomes even more complicated by the added jurisdictional challenges associated with transitional-aged youth. As a workshop participant cautioned, overall in Canada there is still a gap between existing policies and the way they are carried out in practice. Generally, only the most extreme cases of mental distress in children and youth get treatment. The biggest issue, in one participant's opinion, is the lack of a co-ordinated effort in Canada to address mental illness: "It is a huge issue that no one is doing anything about – partly because of the stigma attached to mental illness, and partly because the system isn't organized to do anything about it."

While service provision is generally a provincial responsibility, the federal government delivers some mental health and addiction services to certain sectors of the population. This is the case for Inuit and Status Indians, members of the Canadian Forces, veterans, the RCMP, inmates in federal penitentiaries, arriving immigrants and refugees, and federal public servants. The federal government also has various overarching responsibilities in the health arena, such as health promotion and disease prevention, surveillance, health research, drug approval, and employment and disability benefits. It follows that federal involvement in these areas influences the nature and scope of the provincial provision of mental health services and supports (Standing Senate Committee, 2004).

In 2004, Canada's Standing Senate Committee on Social Affairs, Science and Technology reviewed mental health in Canada. In its final report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addictions* (2006), the Committee discussed the status of Canadians' mental health and illness, including a chapter on youth, as well as presenting policy and service recommendations to improve Canada's mental health care system. The Committee remarked on the complex array of services delivered through federal, provincial, and municipal jurisdictions, and private providers, including initiatives by individuals with mental illness/addictions. One main tenet was to promote positive mental health development by minimizing the risk factors, and supporting the protective factors. Within these efforts, the Committee identified the importance of addressing interactions between the social, psychological, and biological factors, which contribute to mental health functioning. The recommendations also included a focus on multi-departmental action strategies to

further develop the evidence base, which links mental illness to its wide range of determinants of health (Sharma, 2008).

Another important recommendation called for the creation of a national mental health commission that would be an independent, not-for-profit organization at arm's-length both from governments and from all existing mental health stakeholder organizations. Those living with mental illness, and their families should become the central focus of its activities. As a result in 2007, one year after the publication of the Senate report, the Canadian government created the Mental Health Commission of Canada (MHCC) to focus national attention on mental health issues and improve the health and social outcomes of people living with mental illness. The Commission has been endorsed by most levels of government,[10] but operates at arm's length from them. Since its creation, it has been working on four key initiatives: developing a national mental health strategy, creating an anti-stigma campaign, advancing homelessness research demonstration projects, and creating a knowledge exchange centre.

### *Mental Health in the United States*

The Substance Abuse and Mental Health Services Administration (SAMHSA) is a federal agency of the Department of Health and Human Services (HHS). As such, SAMHSA conducts research, and funds and administers grant programs and contracts that support state and community efforts to expand and enhance prevention and early intervention programs and to improve the quality, availability, and range of substance abuse treatment, and mental health and recovery support services in local communities. Mental health services are co-ordinated through each state's department of health.

Recent promising practices initiated or funded by SAMHSA have included:

- ***Policy Academies:*** policy makers on youth and mental health issues benefit from sharing best practices and the evidence base through a policy academy composed of a network of six States that have been selected to examine transition-aged youth issues.
- ***Anti Stigma:*** Every year there is a Children's Mental Health Awareness day. It is a signature event aimed at raising awareness about children's mental health.
- ***Youth M.O.V.E. (Motivating Others through Voices of Experience):*** Youth M.O.V.E National is a youth-led national organization funded in part by SAMHSA. It aims to improve services and systems that support positive growth and development by uniting the voices of individuals who have lived experience in various systems including mental health, juvenile justice, education, and child welfare.

In the United States, Congress established the Comprehensive Community Mental Health Services for Children and Their Families Program, in 1992, to support the development of systems of care for children and youth with serious emotional disturbances and their families.

The SAMHSA program, Systems of Care, is a co-ordinated network of community-based services and supports that is organized to meet the challenges of children and youth with serious mental health needs and their families. It was established to help parents and caregivers address the mental health needs of their children and youth (up to age 17) while managing the demands of day-to-day living.

Adequately meeting these needs requires multiple strategies and agencies. Types of services may range from care co-ordination (case/care management), to child care to community-based, inpatient psychiatric care and overall family support. Since its inception, Systems of Care has helped thousands of children and adolescents with serious behavioural, emotional, and mental health needs make improvements in almost all aspects of their lives. One of the greatest accomplishments noted by Systems of Care has been making services and supports family driven and youth guided (SAMHSA, nd). National evaluation data show that the program helps kids stay out of jail and cuts costs by keeping them out of institutions. As well, parents of youngsters going through Systems of Care are 20 percent more employable (participant Gary Blau, November 3, 2008). Since its inception, the number of families served by Systems of Care and the number of programs added to the network has grown. It also has garnered increasing support across all political parties. "For over 20 years," noted one roundtable participant, "there have been calls for better integrated, more comprehensive systems. Co-ordinated care is a way to rally services around children who need it." While this program has proven effective, roundtable participants also pointed out that in transition ages, sectors are less likely to know how to reach each other. "In child welfare and child health, programs are better co-ordinated, but for youth transitioning to adulthood, programs and services are very disparate."

In 2002, a commission was established to research and identify policies that could be implemented by all levels of government to maximize the utility of existing resources, improve co-ordination of treatments and services, and promote successful community integration for adults with a serious mental illness and children with a serious emotional disturbance (United States, 2003). In the final report of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (2003) the Commission envisioned

> a future when everyone with a mental illness will recover, a future when mental illness can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports essential for living, working, learning, and participating fully in the community. (United States, 2003: 9)

It recommended mental health promotion, expanding school mental health programs, screening for co-occurring mental and substance use disorders, and screening for mental disorders in primary health care, across the life span, and connecting to integrated treatment and supports.

#### *Mental Health in Australia*

The promotion of mental health and prevention of mental illness is a strategic and policy priority in Australia has ranked highly on the public policy agenda for over 15 years. In 1992, the health ministers of all Australian states, territories, and the federal government endorsed Australia's first National Mental Health Policy.[11] The

five-year National Mental Health Plan, accompanied by additional federal funding, was also released in 1992, with time frames for implementing the policy in all states and territories and at the federal level. For the next 10 years, Australian governments implemented two five-year plans to facilitate genuine participation for consumers and caregivers, develop high-quality, community-based mental health care, and outline a broader approach to population-based health promotion and disease prevention. Unfortunately, an investigation in 2002 revealed that despite the increased attention and investments, mental health outcomes in Australia had generally not improved (Ontario, MHCA, 2009).

The government then pursued creating an agenda for mental health reform in Australia through the National Mental Health Strategy. Its foundational documents are the Mental Health Policies (1992 and 2008) together with a Statement of Rights and Responsibilities and the three consecutive National Mental Health Plans. Under the Mental Health Strategy, the Australian government and all state and territorial governments work together to achieve reform of mental health care in Australia. The private sector is also engaged in reform activity.

Australia's Orygen Youth Health (OYH) works to ensure that young people in the transition to adulthood are able to access high-quality mental health, and drug and alcohol services provided in friendly, accessible environments. Its three-pronged approach includes:

- clinical programs specializing in delivering early intervention services to young people with emerging mental disorders, including drug and alcohol issues;
- a research program open to patients using clinical programs that focuses on developing improved treatments and models of care for young people; and
- training and communications, including resources, and consultation to support the translation of best practice treatment models for practitioners working with young people. (Orygen, nd).

### *Youth Mental Health Services – Headspace*

While overarching national policies were being created for the whole of the Australian population, targeted advocacy also led to a government investment in youth mental health in 2005-06, which in turn led to the creation of a mental health initiative for youth called Headspace. Headspace is Australia's National Youth Mental Health Foundation, involving a collaboration of ORYGEN Youth Health Research Centre, the University of Melbourne, the Brain and Mind Research Institute, the Australian General Practice Network, and the Australian Psychological Society. Its objective is to deliver improvements in the mental health, social well-being, and economic participation of young Australians aged 12-25.

Roundtable participants discussed Headspace as a best practice, because it is a multidisciplinary, one-stop shop offering primary care, psychiatric help, drug and alcohol, vocational, and other services. Youth engagement issues are partially addressed by providing services in a youth-friendly environment, where young people are encouraged to be fully involved in their treatment, and services are available in an atmosphere that does not stigmatize mental health issues. The youth-friendly culture at Headspace sites makes treatment for mental health

issues more accessible to young people. Sites are located in 30 rural and urban areas and are accessible to approximately 20 percent of the population, with the intention of expanding services over the next decade. In addition, there are also collaborative learning network and community awareness programs. Through the collaboration with Orygen Research and Orygen Youth Health Clinical Program, practice and research are constantly in dynamic interaction, informing each other on youth mental health issues.

### *Summary*

Mental health appears to be on the policy agenda to varying degrees in Canada, the United States, and Australia; however, youth mental health is not recognized as a discrete, unified area of practice in any of these countries. Although there are programs of a national scope to meet the needs of some youth experiencing mental health problems, there is not an overarching policy or program targeting all youth in response to the unique mental health needs of this phase in the lifecourse and the presentation of mental disorders in this age group.

Understanding current policies and programs in place for youth with mental disorders in Canada, the United States, and Australia, as well as the common mental health issues facing youth in these countries, helped set the stage for the presentations and discussion that followed on the socio-environmental factors influencing brain development and mental health in youth.

## *3. Determinants of Health*

Health determinants emerged in international health literature in the mid 1980s and early 1990s. At the conceptual level, determinants described the ways in which many factors combine to affect the health of individuals, and they explained that, to a large extent, such aspects as where an individual lives, and the state of her/his environment, genetics, income, education, and relationships with friends and family all have considerable impacts on health. Likewise, as population health literature underscores, improving the social, economic, and environmental contexts in which people live goes a long way toward promoting health and preventing disease.

When discussing mental health and the developing brain, participant Dr. Stan Kutcher observed that considering health determinants takes us into an arena likely never imagined by those who initially articulated the concept. However, emerging research in the study of neuroplasticity and epigenetics helps in understanding how the social context and environmental surroundings also affect brain development and mental health. At various points in the life span, the brain has different levels of receptivity to social and environmental stimuli, which affect brain development differently. Between the ages of 15 and 25, there is a neural developmental period when socio-environmental determinants play a key role. At a time when individuals make important decisions – living on their own, completing education, achieving economic independence, and choosing a life partner – neural pathways and brain structure and function are shaped by favourable or adverse experiences. Many participants agreed: brain development during the transition to adulthood is as critical to human development as that which takes place during the first two years of life. In this respect, it is particularly important to consider the interaction between the biological changes and the social contexts that influence behaviour in youth during the transition to adulthood.

### *Health Paradox*

While youth is a prime period for physical health (adolescents and young adults are stronger, faster, and more resistant to the cold, heat, hunger, and dehydration), overall mortality and morbidity rates increase by 200 percent from childhood to late adolescence. This increase is largely due to combined changes in behaviour, social context and the fact that the regions of the brain that govern impulse and motivation are not yet fully formed. Adolescents and young adults generally show higher rates of risk taking, sensation seeking, and erratic, emotionally influenced decisions yet, socially, it is a time of decreased supervision by adults. Roundtable participants discussed the following indicators of risk-taking behaviour in youth.

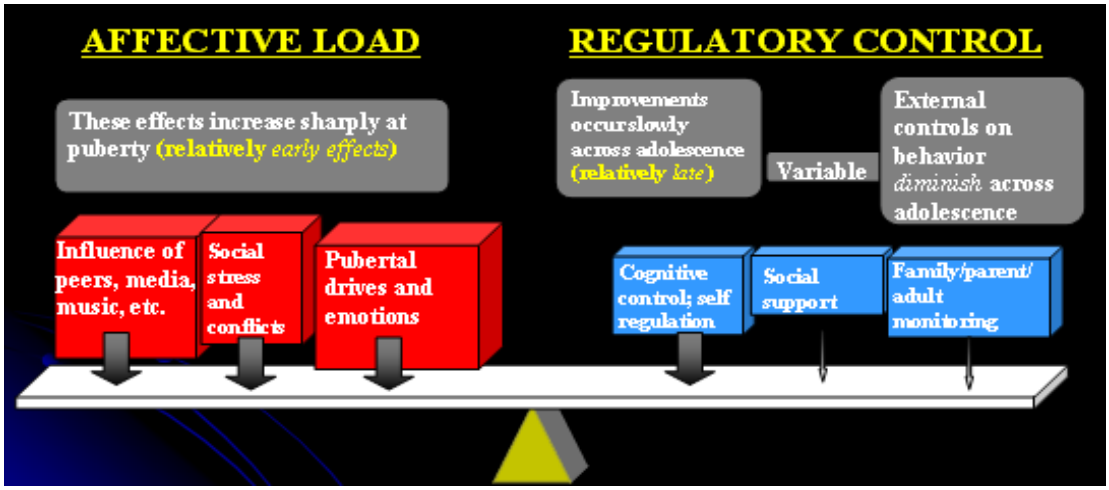
- There is a marked acceleration in criminal behaviour associated with adolescent development, which drops sharply in the early 20s.

- There is an increase in binge drinking, which spikes upward in adolescence and then drops in the early 20s.
- The diagnosis for alcohol dependence is most prevalent in the late teens and then it declines.
- Other mood problems develop in this age group: the growth curves for depression follow the same developmental arc as the trends in binge drinking and alcohol dependence.
- There is also an increased likelihood of developing a serious mental illness for the first time.[12]

Risk-taking behaviours are often attributed to a perceived inability for youth to assess risk properly. However, recent research has shown that young people are aware of the risks and that they are likely to engage in perilous behaviour in spite of them. Scientifically, their behaviour can be attributed to the interactions between affective (emotional and motivational) influences and emerging cognitive capacities that are expressed in a social context.

The participants explained that in this phase of the lifecourse, complex changes in neurobehavioural systems underpin the control over emotions and behaviour. Puberty causes biological changes that, combined with changes in the social context (such as a decrease in adult monitoring), can lead to a type of "tipping point" in adolescence. The influences of peers and the media as well as the affective load of social stress and pubertal drives and emotions can increase sharply during adolescence. Improvements in cognitive control, self-regulation, and access to social support as well as some degree of adult monitoring can help to regulate some of the affective load (see Figure 1).

***Figure 1: The Tipping Point in Adolescence (Ronald Dahl, workshop presentation)***




To understand and ease the transition to adulthood, participants noted the importance of identifying and understanding the stresses placed on youth during this period. They recommended that policies and programs take into consideration the interplay between affective load and regulatory control, considering which factors can help to moderate the increasing pressures placed on young people today.

Further, participants observed that while youth is a period that presents risks, it also provides new social and career opportunities. It is important to consider the influence of these emerging opportunities and new social factors on brain development. Since the brain is shaped by experience, favourable experiences during this time can have lasting positive effects. Precisely because it is a time of heightened emotions, it is a period when individuals can potentially become passionate about sports, music, science, politics, caring for others, and larger purposes, such as changing the world in positive ways. It has the potential to become a window of opportunity for ignited passions to be aligned toward socially positive goals.

### *Opportunity for Prevention*

Studies on the determinants of health made important steps toward devising physical health promotion and illness prevention policies and programs, through the improvement of social and economic conditions. Similarly, the growing scientific body of knowledge about the ways in which social factors influence brain development during adolescence and into early adulthood leads us to understand that this stage in the lifecourse provides an opportunity to make fundamental efforts to prevent mental illness.

Roundtable participants commented that to advance preventive measures against mental illness requires additional research to understand the ways and to what degree different factors (genetic, environmental, and social) interact and affect brain development and mental health during adolescence. They also agreed on the need for evidence-based practices and practice-based evidence. They noted the potential benefits of learning from each other, to avoid going down tried roads and emphasized the need for data to show that programs work, but also to use administrative data when informing policy or identifying best practices. One way to build the evidence base and transfer knowledge gained would be to create an international clearinghouse to share the best practices. Building on this discussion, The Honourable Michael Kirby, Chair of the Mental Health Commission of Canada, described the Commission's mandate to build a knowledge exchange centre. Roundtable participants emphasized the importance of having youth mental health programs, policies, and interventions based on validated, scientifically sound evidence, but identified the challenge of getting service providers to use the latest information; moving the knowledge into practice can be difficult. They also recommended the use of the evidence we have and to continue to do research to find the evidence practitioners need.

The Danish Longitudinal Survey of Children (DALSC) follows 6,000 children born in 1995. The primary aim of the study is to provide representative information about Danish children's family conditions and development. It aims to follow children from birth until adulthood. Four waves have been carried out so far – in 1996, 1999, 2003, and 2007. The fifth wave is planned for 2010.

Participants also identified the research benefits of developing an international longitudinal psychiatric study in Canada, the United States, and elsewhere, using the same language and having the same goals. They discussed the ways in which a broader understanding of brain activity on long-term outcomes could advance new research on the interactions between brain development, genes, and the environment. They also identified the need to involve youth and various cultural communities in the study design.

### *Importance of Experimentation within Limits*

As a result of dramatic social and technological changes, roundtable participants considered how human brain development has changed over the past 20 years. They noted that it is a complex process influenced by stimuli in a child/youth's environment and that it takes longer now due to numerous technological stimuli. Participants advised that while aspects of development have slowed, the period of development actually lasts longer and youth will likely end up smarter than previous generations by the time they reach full transition to adulthood. As a result of the prolonged transition to adulthood, parents today provide more support to youth than was needed in the past.

Despite the need for parental and societal supports during the transition to adulthood, it is also important for youth to begin to learn new things. They need the freedom to experiment, to take risks and learn, yet they also require appropriate supports and supervision to mitigate or minimize the seriousness of the risks they take. The participants reflected on the multiple supports available to parents of young children and the relative absence of guidance for parents of adolescents and young adults. In some cases, parents do not seem able to offer specific guidance, because the changes in society are fundamentally different from what they themselves experienced: social insecurities, risks, and uncertainties appear to increase over time.[13] Researchers commented that when neuro-development is underway and youth need a graded responsibility, and the motivation and discovery frameworks that they can use for themselves, parents and adolescents find themselves without support. They noted the benefits of providing skill sets to parents about how to parent teenagers.

While participants recognized that there aren't firm age boundaries or specific bio-markers for "youth," development does follow set patterns. Research-informed policy would favour a graded approach to independence, emphasizing the importance of developing new skills and competencies within safe limits. When youth show that they can reliably control themselves at a certain task or in certain situations, they should be permitted to gain increased freedom (e.g., a graded approach to independent driving). Participants advised more steps and more evaluations in this process, because some emerging adults require larger amounts of support and supervision. Researchers also emphasized the importance of incremental improvements: they advised giving youth an increasing amount of freedom to experiment and make some mistakes, within reason, since this is an important part of learning. Taking into account later ages of home leaving and the

transition to full-time employment, additional supports for families in general are required.

## 4. Vulnerability, Risk, Resilience, and Recovery

Resilience can be broadly defined as positive patterns of adaptation in the context of past or present adversity, trauma, or disaster. For youth transitioning to adulthood, resilience characterizes trajectories marked by unexpectedly positive adaptation or recovery in adulthood despite challenging or threatening circumstances in their lives (Masten, 2007). At its core, resilience is a capacity for change. However, roundtable participants cautioned that it is not an individual trait or a personal attribute, but rather it seems to be shaped by life circumstances. Researchers studying resilience have observed that there is a plurality of the events, culture, society, and other aspects of an individual's life that all work together to contribute to a person's own resilience.

During the transition to adulthood, a convergence of change lends itself to resiliency: many young people make a positive shift during the transition to adulthood. As the brain develops and is exposed to new contexts and opportunities, a change in expectations can serve to open new doorways for youth. Changes in the social context, combined with new opportunities, provide a chance for some youth to turn their lives in a new direction. In this stage of development, a dynamic relationship exists between vulnerability, risk, and resilience, and research has demonstrated that many ingredients come into play to shape development in positive and negative ways during this unique developmental phase.

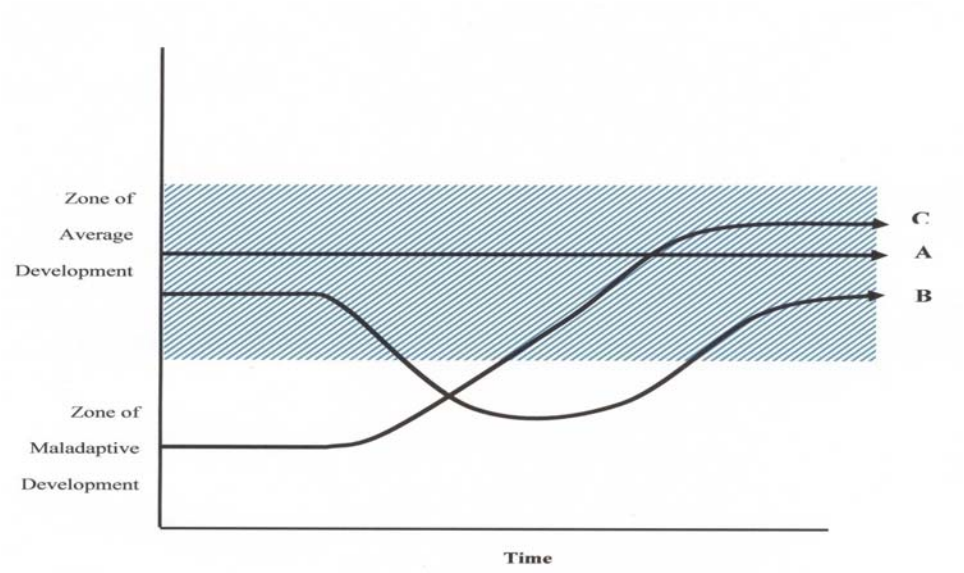
> Many traditional world views have resilience knit into their cultural fabric as can be seen in the First Peoples principles for well-being of children and youth. These principles encapsulate many of the components for resilience: self-determination, the importance of intergenerational participation in the community, active engagement of young people, a holistic approach to well-being, respect for culture and context, and shared responsibility through the balance of power. However, the current context for many First Nations in Canada is such that the socio-economic conditions, combined with the historical trauma from residential schools and subsequent intergenerational effects on parenting and discrimination have adversely affected their overall health and well-being.

### Characteristics and Patterns of Resilience

Dr. Ann Masten described three principal patterns of resilience. The first was termed "average" or "stress resistant," where an individual consistently maintains average development as he or she transitions to adulthood (see pattern A, below). She explained that this pattern is exemplified in cases when an individual does consistently well in adolescence. In most cases, individuals following this pattern will make a positive transition to adulthood. A second observed pattern starts at about average development, drops for a given period of time and then comes back to the average development zone (pattern B). This pattern has been observed, for example, in some cases when a youth was temporarily affected by mental illness or in other cases, after a catastrophic event had occurred. The final pattern discussed was one that starts far below average and comes up to achieve very successful development (pattern C). In terms of resilience studies, the interest is in understanding this last pattern and in identifying the elements that help youth

who started out with poor development, and were able to achieve success in adulthood despite the adverse conditions with which they were faced.

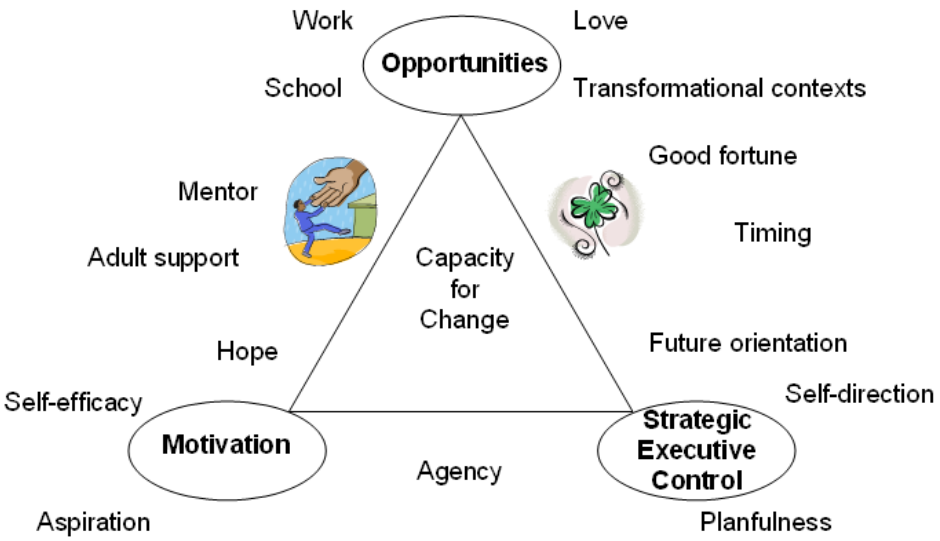
***Figure 2: Patterns of Resilience and Recovery (Ann Masten, workshop presentation)***




Dr. Masten's research has shown that competent and resilient youth have more resources at their disposal including better parenting and stronger intellectual skills. Planned and motivated behaviours also have positive effects for the future, that is, planning for the future predicts positive change in the transition to adulthood. She observed that the capacity for change exists in the transition to adulthood and that the window of opportunity for success that opens results as a dynamic between motivation, strategic executive control, and opportunities. According to emerging research in neuroscience, the prefrontal cortex (still developing in late adolescence and early adulthood) is responsible for executive control. It is only within the last decade that executive functions have come to be fully appreciated for their impact on cognitive and emotional functioning and, more specifically, cognitive inhibition and initiation, self-regulation, and motor output. In general, executive functions are a constellation of related, yet distinct abilities that provide for intentional, self-directed, and goal-directed action, including planning and organization.

The model below was presented at the workshop on November 3; it captures the common elements that influence positive change during the transition to adulthood. This model shows that resilience is the result of the dynamic between opportunities, brain development (strategic executive control), and motivation. Elements, such as adult support, hope, agency, and self-direction are predictors for positive change in this transitional window.

***Figure 3: Elements for Positive Change (Ann Masten, workshop presentation)***




## *Cascading Effects – Scaffolding Increases Resilience*

In developmental literature, windows of risk and opportunity have been noted during periods of particularly concentrated change in individuals and their social contexts. Youth, a period marked by several transitions (out of the parental home, into post-secondary education, into marriage, parenthood, or other new situations) is viewed as a period of vulnerability or opportunity, when much of an individual's life is in flux. In developmental literature, scaffolding is the term used to designate the supports and guidance provided by parents, mentors, or organizations that help youth effectively function beyond their independent capabilities (or in spite of their vulnerabilities) and support successful transitions to adulthood (Masten, 2007).

Given the window of opportunity for change in the transition to adulthood and factors like good parenting, mentorship, and school supports that increase resilience, it becomes more important to provide scaffolding for youth deemed at risk, to increase their resilience. In particular, roundtable participants discussed the provision of two important types of support for youth: sustained scaffolding for youth in low socio-economic settings, in foster care or otherwise deemed at risk, and early intervention and scaffolding for youth at risk of developing a mental illness

## *Sustained Scaffolding in Low Socio-Economic Settings, Foster Care, or Youth Otherwise Deemed at Risk*

Roundtable participants observed that for youth who experience particular risks and who do not have the benefit of a sustained family and social supports provided to most other youth during the slow transition to adulthood,[14] prolonged

supports are required to increase their resilience. Children in foster care, for example, move out of care precisely at the time when supports are required to help them transition successfully to adulthood. Their supports are dropped around age 18, an age when children in advantaged families benefit from prolonged and sustained support from their parents. The participants pondered how we might be able to begin to support youth as a society, in cases where parents or guardians are not able to offer guidance. They also discussed the need to be strategic about interventions. Programs targeting these youth throughout the transition to adulthood (sometimes into their 30s) can help to provide some of the necessary supports that are otherwise lacking.

Researchers also discussed the importance of better understanding socio-cultural contexts of brain development in adolescence by looking at cultural and minority groups individually. To increase practitioners and policy makers' understanding of the specific strengths and needs of cultural communities, information must be synthesized and disseminated in a way that encourages a commitment to change. Participants observed that most successful interventions for youth at risk build cultural connections and are developed to build on the input and assets that exist in the communities. They advised, however, that more research is required on the provision of services to specific cultural groups or communities that appear to suffer from a disproportionate burden of mental ill health.

Although researchers have contributed significantly to better understanding the transition to adulthood, aspects of it remain poorly understood. Roundtable participants emphasized the need to comprehend the impact of current societal changes and catastrophic events on youth. Over the past decade, there have been major dislocations in terms of the global economy and the types of skills needed to move effectively into the workplace. The speed at which technological tools change has accelerated and a much more complex set of skills is required to gain a comparative advantage in the work force now than was required 30 years ago. Participants also observed that society as a whole has a much lower tolerance for eccentric, creative, deviant behaviour than in the past.[15]

### *Early Scaffolding for Youth at Risk of Developing a Mental Illness*

Participants also discussed the substantial economic benefits of preventing mental illness and the need to provide reinforced supports at an early age to youth showing signs of developing a mental illness. Epidemiological research has demonstrated the considerable burden that mental disorders place on the world as a whole – more than 10 percent of lost years of health life (disability-adjusted life years) and over 30 percent of all years lived with disability (WHO, 2001). The weight of this disease burden is caused by the relatively high prevalence of mental disorders, their often chronic or recurring nature, and the severity of disability associated with many mental disorders. Low rates of case recognition and the lack of access to effective treatment compound the problem.

Studies by the WHO show that early intervention is beneficial in mental health treatment, because mental illness is more easily treatable when symptoms are first manifested. It also reaps rewards over time. By helping young people at the onset of a mental illness, it enables youth to better insert themselves into the work force and contribute to family and community life.

## *5. Treating Youth with Mental Illnesses: Creating an Integrated System of Care*

Mental health services in Canada, the United States, and Australia follow a traditional pediatric versus adult system of delivering care, despite the fact that mental illnesses in youth have a different pattern of onset and a more significant burden of disease than at other points in the life span. Yet, like individuals with physical illnesses, youth experiencing mental health problems are provided with either child or adult diagnostic services and treatment depending on their age. Adolescent mental health services are typically embedded within child-oriented service settings, and they are curtailed in the mid to late teens, while adult mental health services are largely centred on late-stage mental illness, focusing on meeting the needs of middle-aged patients.

Roundtable participants remarked that the mental health field seems to have begun to recognize that child and adult mental health systems, as well as other child/adult service sectors, may not serve young people adequately during the transition to adulthood. The fractured mental health system has severe gaps and challenges from the policy level through to program design and service delivery, at a time in the lifecourse when the mental health supports would benefit most from being strengthened.

### *Integrating Mental Health into the Health Care System*

Research findings demonstrate that the prevalence and incidence for mental disorders among young adults 18-24 is higher than at any other point across the life span. Yet despite the significant impact of mental illnesses at a time when young people make critical decisions about their education, employment, and living situations, roundtable participants observed that the services available to youth are inadequate. They are split across multiple levels of government or different program areas, and are cut off at predetermined (but inconsistent) ages. Consequently, as observed Dr. Patrick McGorry, there is maximum weakness and discontinuity in the system just when it should be at its strongest.

Primary care is the point of entry for the majority of people seeking medical health care, and roundtable participants noted that it is the logical setting in which youth mental disorders should be identified. Yet generally, the health care systems in Australia, Canada, and the United States have a strong primary system for physical health, but few points of access for youth with mental health issues. The important role of primary care is also founded on recognition that decisions in primary care take account of patient-related factors – family medical history, and patients' individual expectations and behaviours. The benefits that could be gained by integrating a mental health checkup into the overall pediatric physical checkup are significant. However, this would require training all providers of primary care in mental health care. One roundtable participant cautioned that moving forward with a "reinforced" model of primary care that included identification of mental illnesses in youth would also require a careful analysis to

establish a referral system for management of severe cases and patients requiring access to diagnostic and technological expertise.

Roundtable participants also discussed difficulties with mental health care provision to youth in the secondary and tertiary systems. The fact that the secondary system, which provides specialized care, is fragmented further complicates access to mental health services. Multiple secondary services exist, such as organizations providing limited youth housing services or some youth drug and alcohol rehabilitation, but there isn't a structure to co-ordinate them. The tertiary care (emergency services) provided by hospitals is generally an undesirable point of entry, because the system is overburdened and does not provide continuous, sustained care over time.

Roundtable participants noted that to enhance mental health service delivery for young people, youth mental health services need to be cross-sectoral, integrated, co-ordinated, flexible, and funded equivalently to adult mental health services. They argued that the most promising approach for reducing the burden of mental illness would be to increase access to treatment through a comprehensive system of primary health care: primary care services supported by secondary and tertiary care facilities, physicians, and specialists. They noted that what is needed is a continuing, seamless care approach to handle the long-term nature of mental disorders.

The Transition to Independence Process (TIP) System engages youth and young adults in the planning process for their own future, and provides them with developmentally appropriate services and supports. It involve youth and their families and other informal key players in a process that prepares and facilitates them in their movement toward greater self-sufficiency and successful achievement of their goals.

Roundtable participants also reflected on the fact that the pediatric model is not well suited for youth mental health care: there is a "cultural"[16] disconnect for young people since child services tend to be family oriented, and adult services are more individualized (one-on-one), with an abrupt shift in care models when a young person makes the transition over to the adult model. The current available services do not reflect the unique ways in which a young person transitioning to adulthood may vacillate between the need for their family's involvement to support their mental health and for achieving their own individual independence.

The roundtable participants discussed the need to re-engineer primary care for youth. They reflected on the potential to make a long-lasting difference by investing in their mental health. Many benefits could be gained by creating separate practices for youth mental health (similar to geriatric psychiatry for seniors) that are developmentally appropriate to address the onset of disease and improve the transition of youth with mental illness to adulthood. Specialized services for youth would provide developmentally appropriate assessments, treatments, and social and vocational recovery. There is also a need to learn more about the effectiveness of current youth programs. Researchers and policy

makers expressed an interest in developing and accessing a compendium of best or promising practices to treat mental illness in youth.

The system of care and the scaffolding available to youth with mental illnesses can be further reinforced by providing support from other sectors, such as employment, housing, and welfare. Fully involving these sectors could improve the programs and services for people suffering from mental illness since partnerships with other sectors enhance the effectiveness of interventions and increase the resources available to youth, through joint actions. For example, to ease access to mental health services and provide early intervention, they observed that treatment needs to be close to home. There is a potential to partner with schools and provide the treatment in the schools after hours.

The participants also observed that in the transition years, service providers from welfare, justice, health, etc., do not know how to connect with service providers in other sectors. In Canada, the United States, and elsewhere, the age definition for youth services continues to be an issue as youth policies vary in the artificial boundaries they create around "childhood" and "adulthood." An optimal service delivery system would allow youth mental health professionals to work with service providers in other sectors to help youth transition smoothly to adulthood.

### *Training Needs*

Recent survey findings indicate that few service providers for youth have the training to identify and treat youth suffering from mental illness. The roundtable participants reflected that further educating people on the front lines could facilitate access to referrals to specialized mental health care when necessary and be a first step in addressing the structural shortage of mental health human resources. They also observed that general training is required for service providers and other professionals to interact with youth since teachers, physicians, policy makers, and social workers generally aren't informed about developmental process or supporting and enhancing positive development. One roundtable participant noted that in Canada, according to a report by the Canadian Centre for Substance Abuse, 30 percent of social workers have the option to take addictions counselling

The Canadian Looking After Children Project (CanLAC), based on the model developed in the United Kingdom in the early 1990s, attempts to improve the outcomes of children and youth in care by improving the quality of state parenting that they receive. This is achieved by building partnerships between the caregiver(s), child welfare worker, child or youth in care, biological family members, and other important people in the child or youth's life. CanLAC is a strengths-based model that moves beyond harm reduction to maximizing well-being; aiming for outcomes for children and youth in care that are similar to those of children and youth in the general population. At the core of CanLAC is an emphasis on promoting dialogue between the child/youth, caregiver, child welfare worker, and other important partners to create a comprehensive and collaborative plan of care to guide and monitor the development of children and youth in care. Further, it allows for a systematic evaluation of child outcomes and interventions at individual, organizational, and national levels, through data aggregation. This allows for the development of national data regarding the experiences and outcomes of children and youth in care (CWLC, 2009).

course; of those, only half are required in order to graduate. Other participants observed that there are cohorts of physicians going into family practice who don't have any training in child or youth mental health. Participants suggested public and professional awareness, education, national and international campaigns, and a variety of actions involving governments, health officials, patients, and the media. The ultimate goal of these efforts would be to facilitate social inclusion and access to care.

Specialized training would also be important for police who are often the first point of contact for youth with mental health issues. Participants advised on the need to stop criminalizing mental health and divert youth suffering from mental disorders away from the criminal justice system. They stated the need for community-based residential programs with resources and clinical support. They also supported the need for emergency teams to respond to psychiatric emergencies (not police).

### *Youth and Family Driven/Engaged/Empowered Approaches*

To facilitate early intervention for youth mental health issues, it is also important to eradicate the stigma that can sometimes inhibit people from speaking about their or their family member's mental illness and seeking the help they require. A comprehensive continuum of care would include mental health and wellness promotion, mental illness prevention, risk reduction, and coping enhancement. As a first step, roundtable participants advised that parents and families need to be more informed on mental health causes/prevalence/symptoms/treatments, including ways to reduce risk and improve resilience. They noted that it is equally important to involve youth in their treatment and recovery program, to ensure that they stay engaged in the treatment process for as long as they require care.

Located in Halifax, Lang House practices recovery with youth. It is a unique non-profit, charitable organization committed to empowering youth 16-30 years of age with a mental illness. It is community-based, youth-focused, and youth directed. It is committed to providing critical support and access to resources to enable youth with mental illness to reduce isolation and address needs for returning to school, seeking employment, re-establishing a peer group, making healthy lifestyle choices, and living independently.

The roundtable participants emphasized the importance that new models of care for youth be patient centred and family driven. They noted that the health sector must establish mechanisms through which youth can actively participate in identifying health issues that are important to them, in establishing priorities and developing strategies (prevention/mitigation/treatment/recovery) to meet their mental health needs the most effectively. They also advised that individuals are better prepared for the transition to adulthood when they play an active part in decision making.

Youth have clearly articulated their desire to influence policies and services developed to support the safe and successful transition from childhood through to adulthood. Participants in adolescent development also support youth

involvement and have outlined the benefits to both youth and society when opportunities are provided for youth to contribute to policy and program development and service delivery. Mental health services also need to be easily accessible and youth informed about their rights and the interventional choices available.

## *Conclusion*

Youth is a period marked by transitions out of the parental home, into post-secondary education, marriage, parenthood, or other new situations, presenting both vulnerability and opportunities for development and change. It is a unique period in the lifecourse that can be a natural time of motivational learning – a time to ignite passions for sports, literature, or caring for others. Unfortunately, it is also a period of increased risk of developing a mental illness. If left untreated, mental illness can affect educational achievement, occupational or career opportunities and successes, and the formation and nature of personal relationships. The impacts may extend throughout an individual's life, with ripple effects on a young person's family, workplace, and community. Participants at the roundtable event on Health Transitions to Adulthood emphasized that in Canada, the United States, and elsewhere there is a need and an opportunity for policy attention.

Throughout the discussion, academics, policy makers, service providers, and people who had used youth mental health services discussed the ways in which policies and programs for youth could be improved, given the current knowledge and emerging scientific research.

#### *1. Collaborate to raise awareness, inform policies, and reduce stigma by addressing the myths and misconceptions that give rise to it.*

Combined efforts in Canada, the United States, and elsewhere would be useful to increase public awareness about youth mental health issues and to reduce the discrimination that still exists against people with mental illnesses, by addressing the misconceptions that give rise to stigma. In many instances, stigma impedes young people and their families from seeking help, and it limits their ability to become active participants in their communities and the work force. Roundtable participants discussed the ways in which public health professionals can make an important contribution to the process of gaining political support, by providing decision makers with solid information on the prevalence, consequences, and burden of mental disorders, and by carefully documenting the proven and promising interventions that can lead to their prevention or management.

#### *2. Recognize the central role of youth and families in research, policy, and program/service development and delivery, including in governance structures.*

Young people and families from diverse cultural communities and of differing socio-economic backgrounds need to be involved in all aspects of mental health service provision, from research design, to policy development, to program and service delivery. Understanding the challenges facing young people today, the different ways in which they and their families or communities cope with adverse events, and their involvement in their treatment design can help researchers, policy makers, and practitioners meet their needs. Roundtable participants throughout the day underlined the ways in which a young person's involvement in

these processes can increase their resilience and positively influence their mental health outcomes.

***3. Integrate mental health services with the overall health system and with other youth service systems.***

In Canada, the United States and elsewhere, a co-ordinated and integrated system of care is required to better assist youth facing mental health issues. Roundtable participants discussed the efficiency that could be gained by integrating mental health services within existing primary health care services. They also discussed the ways in which fundamental structural shortages in mental health care providers could be addressed by fully involving sectors, such as employment, housing, justice, and welfare. If these sectors were to co-ordinate their efforts around the needs of their young clients, and if programs were co-ordinated, they could enhance the effectiveness of interventions and increase the resources available to youth, through joint actions.

***4. Consider needed supports (or scaffolding) for young people as a constructive lens to address research, policy, and programs.***

Scaffolding can be provided by putting appropriate policies into place that aim to support youth who experience particular risks. At the roundtable, the participants discussed scaffolding for two different types of youth at risk: early scaffolding for youth experiencing the onset of a mental illness and prolonged scaffolding for youth living in poverty or transitioning out of foster care. For youth at the onset of a mental illness, this involves early treatment, and providing co-ordinated supports from various sectors to youth and their families. For those who are otherwise deemed at risk, such as youth living in poverty or who are transitioning out of foster care, scaffolding implies policies and programs that would allow them to benefit from the type of supports provided by the families of other youth for the increasingly prolonged period that marks the transition to adulthood. Roundtable participants cautioned that just as the change window opens for these most vulnerable youth, youth at risk are more apt to fail if they don't receive appropriate scaffolding.

***5. Develop appropriate responses to meet the mental health needs of Indigenous populations and other cultural groups.***

Many traditional world views have resilience knit into their cultural fabric, yet despite valuing self-determination, intergenerational participation and a holistic approach to well-being, Indigenous youth in many Canadian First Nation and Inuit communities suffer from high rates of suicide and other indicators of distress. The roundtable participants discussed the need to understand the strengths and specific supports that are provided in different cultural communities and to also understand where supports are lacking in order to develop targeted, culturally appropriate interventions and treatment.

***6. Collect comparable data across countries by collaborating in a longitudinal cohort study.***

Roundtable participants observed that in Canada and the United States significant gaps in the evidence base still exist. They identified the lack of longitudinal cohort data on youth mental health as a critical missing element. This information is critical to show long-term results of interventions, but also to further inform the benefits of early prevention and treatment of mental illness.

***7. Share knowledge about research, policy and program experience, and challenges.***

Moving the best practices and information from academics and researchers to the service provider is critical. Roundtable participants from the United States, Canada, and Australia agreed that they would benefit from identifying best practices both in terms of effective policies and practices and by sharing this information across international borders.

## *Annex 1*

### *Canada–US Workshop on Youth Mental Health*

### *Healthy Transitions to Adulthood: Moving to Integrated Mental Health Care*

***November 3, 2008***
***Woodrow Wilson International Center for Scholars***
***Washington, DC***

***Agenda***

**8:30 Arrival**

**8:45 Welcome**

- ***David Biette**, Director, Canada Institute, The Woodrow Wilson International Center for Scholars*
- *Co-chairs **Dr. Heather Munroe-Blum**, Principal and Vice-Chancellor of McGill University and **Dr. Howard Alper**, Chair of the Science, Technology, and Innovation Council, Government of Canada*

**8:55 Introductions**

**9:25 *Guy Saint-Jacques,*** *Deputy Head of Mission, Embassy of Canada*

**9:35 Setting the Stage – Overall Theme: Healthy Transitions to Adulthood: Moving to Integrated Mental Health Care** *(Chaired by Dr. Howard Alper)*

- ***Michael Kirby**, Chair of the Mental Health Commission of Canada*
- ***Dr. Gary Blau**, Chief of the Child, Adolescent and Family Branch, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services*

**10:05 Discussion**

**10:30 Break**

**10:45 Recovery and Resilience** *(chaired by Dr. Heather Munroe-Blum)*

- ***Judy Finlay**, Associate Professor, School of Child and Youth Care, Ryerson University and Co-Chair, Mamow Sha-way-gi-kay-win: North-South Partnership for Children*
- ***Dr. Ann Masten**, Distinguished McKnight University Professor, Institute of Child Development, University of Minnesota*
- ***Andy Cox**, IWK Health Centre, Mental Health Patient Advocate for Children and Youth and member of the Board of Directors, Mental Health Commission of Canada*

**11:15 Discussion**

**11:45 Lunch**

**12:45 Determinants of Health** (*Chaired by The Honourable Michael Kirby)*

- ***Dr. Stan Kutcher**, Sun Life Financial Chair in Adolescent Mental Health, Professor, Department of Psychiatry, Dalhousie University and WHO/PAHO Collaborating Center in Mental Health Training and Policy Development*
- ***Dr. Ronald E. Dahl**, Staunton Professor, Pediatrics & Psychiatry, University of Pittsburgh*
- ***Bernard Richard**, Province of New Brunswick, Ombudsman and Child and Youth Advocate*

**1:15 Discussion**

**1:45 Systems of Care** *(Presentations & Discussion chaired by Dr. Howard Alper)*

- ***Dr. Patrick D. McGorry**, Professor of Youth Mental Health, University of Melbourne Australia; Executive Director, ORYGEN Research Institute; Director of Clinical Services, ORYGEN Youth Health and Chair, Headspace*
- ***Dr. Simon Davidson**, Chief of Psychiatry and Medical Director Mental Health Patient Service Unit Children's Hospital of Eastern Ontario; Chain of Division of Child and Adolescent Psychiatry, University of Ottawa; Chair, Child and Youth Advisory Committee, Mental Health Commission of Canada*
- ***Dr. Hewitt B. "Rusty" Clark**, Professor, Department of Child and Family Studies, University of South Florida*

**2:15 Discussion**

What is needed to implement integrated systems of care on a broad scale? How do we move from evidence to practice? What policies are needed to enable an integrated and culturally appropriate approach to care?

**2:45 Break**

**3:00 Tour de table and discussion** *(Chaired by Dr. Howard Alper and Dr. Heather Munroe-Blum)*

**4:15 Closing Remarks and Next Steps** (*Mr. Thomas Townsend, Executive Head, Policy Research Initiative, Government of Canada)*

**4:30 Adjourn**

***A reception hosted by the Woodrow Wilson International Center for Scholars will immediately follow.***

## *Annex 2*

### *Canada–US Workshop on Youth Mental Health*

### *Healthy Transitions to Adulthood: Moving to Integrated Mental Health Care*

#### *List of Confirmed Participants and Speakers*

| PARTICIPANT | ORGANIZATION |
|---|---|
| **Abele, Daniel** | ***Embassy of Canada**, Head, Research and Academic Relations* |
| **Alexander, Marvin** | ***Mid-South Health Systems, Inc.**, TFC Therapist, AFK Youth Involvement Consultant* |
| **Alper, Dr. Howard** | ***University of Ottawa**, Distinguished Professor*<br><br>***Science, Technology, and Innovation Council, Government of Canada**, Chair* |
| **Biette, David** | ***The Woodrow Wilson International Center for Scholars**, Director, Canada Institute* |
| **Blau, Gary** | ***Substance Abuse and Mental Health Services Administration**, Chief, Center for Mental Health Services/Child, Adolescent and Family Branch* |
| **Brennan, Eileen** | ***Portland State University**, Associate Dean and Professor of Social Work* |
| **Chalk, Rosemary** | ***The National Academies**, Director, Board on Children, Youth, and Families* |
| **Cox, Andy** | ***IWK Health Centre**, Mental Health Patient Advocate for Children and Youth*<br><br>***Mental Health Commission of Canada**, Member of the Board of Directors* |
| **Clark, Hewitt B. "Rusty"** | ***University of South Florida**, Professor, Department of Child and Family Studies* |
| **Dahl, Ronald E.** | ***University of Pittsburgh**, Staunton Professor, Pediatrics and Psychiatry* |

| PARTICIPANT | ORGANIZATION |
|---|---|
| **Davidson, Simon** | ***Children's Hospital of Eastern Ontario**, Chief of Psychiatry and Medical Director, Mental Health Patient Service Unit*<br><br>***University of Ottawa**, Chair, Division of Child and Adolescent Psychiatry*<br><br>***Mental Health Commission of Canada**, Chair, Child and Youth Advisory Committee* |
| **Dawes, Daniel** | ***American Psychological Association**, Senior Legislative and Federal Affairs Officer, Office of the Public Interest/Government Relations* |
| **Davis, Maryann** | ***University of Massachusetts Medical School**, Research Associate Professor, Center for Mental Health Services Research* |
| **Dell, Colleen** | ***Carleton University**, Associate Professor, Department of Sociology and Anthropology*<br><br>***Canadian Centre on Substance Abuse**, Associate* |
| **Finlay, Judy** | ***Ryerson University**, Associate Professor, School of Child and Youth Care*<br><br>***Mamow Sha-way-gi-kay-win: North-South Partnership for Children**, Co-Chair* |
| **Goldman, Howard H.** | ***University of Maryland**, Professor of Psychiatry* |
| **Goldman, Sybil** | ***Georgetown University Medical Center**, Assistant Professor, Department of Pediatrics* |
| **Guzder, Jaswant** | ***Jewish General Hospital**, Head of Child Psychiatry and Director of Child Day Treatment*<br><br>***McGill University**, Associate Professor, Psychiatry* |
| **Kirby, Michael** | ***Mental Health Commission of Canada**, Chair* |
| **Kroes, Genevieve** | ***Policy Research Initiative**, Senior Policy Researcher and member of the PRI Secretariat* |
| **Kutcher, Stan** | ***Dalhousie University**, Director of the WHO Collaborating Centre in Mental Health and Sun Life Financial Chair in Adolescent Mental Health and IWK Health Centre - Maritime Psychiatry* |
| **La Traverse, Valerie** | ***Embassy of Canada in Washington**, Science and Technology Counsellor* |

| PARTICIPANT | ORGANIZATION |
|---|---|
| **Leadbeater. Bonnie** | ***University of Victoria**, Professor, Psychology Department*<br>*Director, Centre for Youth and Society*<br>***Child & Youth Health Research Network**, Co-Director* |
| **Manion, Ian** | ***Children's Hospital of Eastern Ontario**, Executive Director,*<br>*Provincial Centre of Excellence for Child and Youth Mental Health* |
| **Masten, Ann S.** | ***University of Minnesota**, Distinguished McKnight University*<br>*Professor, Institute of Child Development* |
| **McGorry, Patrick D.** | ***University of Melbourne Australia**, Professor of Youth Mental Health*<br><br>***ORYGEN Research Centre**, Executive Director*<br><br>***ORYGEN Youth Health**, Director of Clinical Services* |
| **Meikle, Victoria** | ***McGill University**, Senior Policy Advisor to the Principal and Vice-Chancellor* |
| **Munroe-Blum, Heather** | ***McGill University**, Principal and Vice-Chancellor* |
| **Quirion, Rémi** | ***McGill University**, Professor*<br><br>***Douglas Hospital Research Centre**, Scientific Director*<br><br>***Canadian Institute of Health Research**, Scientific Director,*<br>*Institute of Neuroscience, Mental Health and Addiction* |
| **Richard, Bernard** | ***Province of New Brunswick**, Ombudsman and Child and Youth Advocate* |
| **Saint-Jacques, Guy** | ***Embassy of Canada**, Deputy Head of Mission* |
| **Saulnier, Marcel** | ***Health Canada**, Director General, Policy Co-ordination and Planning Directorate* |
| **Spear, Linda** | ***Binghamton University**, Distinguished Professor of Psychology* |
| **Townsend, Thomas** | ***Policy Research Initiative**, Executive Head* |
| **Watling, Judy** | ***Policy Research Initiative**, Director General, Sustainable Development* |

## *Annex 3*

### *December 3, 2008*

### *Healthy Transitions to Adulthood: Moving to*

### *Integrated Mental Health Care*

***Draft Priority Items Identified in the Tour de Table at the November 3, 2008 Canada – US Workshop on Youth Mental Health***

**A. POSSIBLE SHORT-TERM ACTIVITIES:**

1. Enlarge the MHCC "evergreen document" (or road map) on mental health to an international scope, to plan for the medium to long term *(MHCC/ Dr. Stan Kutcher/Dr. Simon Davidson)*

2. Explore collaboration with several Canadian provinces on US policy academies, including the possibility of one on Indigenous people *(MHCC/Georgetown University)*

3. Establish a Canada/US and others learning network (universities/researchers) to develop a common research agenda on youth mental health and developmentally appropriate care and to transfer knowledge on research findings, pilots, and broad practices; PRI to share co-ordinates of participants to begin; network could be supported with Web 2.0 tool at PRI

4. Explore ways to adopt the Transition to Independence Process (TIP) system in Canada *(MHCC/Dr. Rusty Clark)*

5. Present Canada/United States/Australia research findings on SAMHSA Webinars *(Dr. Gary Blau)*

6. Jointly develop messages/a social marketing plan to generate public awareness about child and youth mental health and pursue discussions on an International Youth Mental Health day for Canada, the United States, Australia, and others to celebrate mental health – involve celebrities and role models *(MHCC/Dr. Gary Blau)*[17]

7. Explore partnership between Canada and US on:

- care models for youth dealing with substance abuse and mental health issues *(MHCC/Georgetown University)* and
- mental health promotion research *(Canadian Institute for Health Research/National Institute for Mental Health)*

## B. Medium- /Long-Term Priorities

| Objectives | *Activities* |
|---|---|
| **1. Develop a body of knowledge on youth mental health and transfer information across Canada-United States-others.** | |
| **Develop cross-border initiatives to collect and analyze data on youth mental health** | Develop integrated data systems to glean information from existing administrative data; Manitoba example and Kids Integrated Data Systems (KIDS) in Philadelphia.<br><br>Further refine the evidence base by collecting biological data along with outcome data, to study the interaction between brain development and the environment.<br><br>Develop a joint United States-Canada-Australia (and others) longitudinal birth cohort survey and start a second wave of the study concurrently, beginning at puberty. |
| **Develop a culturally specific body of knowledge to track which youth mental health practices are working and for whom in Canada-United States-Other** | Develop a Canada-US partnership to study Indigenous child and youth mental health.<br><br>Commission a systematic review in Canada and the United States to determine evidence of what works for whom and distribute this information widely. Follow up to see whether the information was used to inform plans, policies, and service delivery.<br><br>Develop a compendium of culturally specific best practices for large immigrant populations and Indigenous peoples. There are commonalities but also unique protective systems in these communities. There are also things that researchers and practitioners need to know to select practices that will work for families and in a given cultural context and to build on |

| Objectives | *Activities* |
|---|---|
| | their knowledge and what is working. Cultural diversity and Indigenous issues are a neglected area for educators, nurses, mental health practitioners, and people on the front line. |
| **Set up information networks to share research findings and best practices across Canada, the United States, and other countries** | MHCC and Georgetown University to collaborate on the study of youth co-occurring mental health and addiction disorders.<br><br>Jointly develop a communications strategy to transfer knowledge on research findings, trials, and pilots to broad practice; package information for different audiences.<br><br>Share models and best practices drawing from information from the United States, Canada, Australia, and New Zealand using the MHCC Knowledge Exchange Centre as a clearinghouse. |
| **2. Partner to develop integrated models of care for youth.** | |
| **Develop an integrated curriculum for youth mental health service providers** | Create a specialized field for youth mental health. There is a need for professional training, a body of knowledge, and programs specific to youth care which is neither pediatric nor adult (analogy to geriatric specialty).<br><br>Develop a network of Canadian and US universities to develop a mental health curriculum appropriate for the transitional age group. Courses could include knowledge of neurobiology, positive developmental psychology, etc., so mental health professionals would be better informed about conditions specific to youth. Collaborate with youth to ensure curriculum is relevant. |

| Objectives | *Activities* |
|---|---|
| **Develop a model that integrates mental and physical health services** | Jointly develop a framework to integrate mental and physical health services for youth, given that this developmental period is a key time to have a positive effect on mental health. Move away from silo-ed practice, research, and fragmentation of funding.<br><br>Integrate mental health and other systems that promote development and health. Exciting models of integrated care have been developed at the community level. Disaster response teams have also shown success in this regard.<br><br>Examine how first responders are being used in Canada and the United States, in remote areas and urban centres, and develop more efficient models for response for mental and physical health human resources. |
| **Better integrate youth services that support moving to a productive life** | Develop community-based services for youth that are developmentally appropriate.<br><br>Focus on a different set of transitions: help young people move from services to productive lives (not to adult services).<br><br>Explore building on the trial of supportive employment programs for youth with mental health issues who are transitioning to adulthood (program at Dartmouth testing discrete intervention within a system of care that requires collaboration with vocational rehabilitation, employment sector, rehabilitation and the private sector raised by Dr. Howard Goldman). |
| **3. Jointly develop campaigns to fight stigma on youth mental health and inform public policy in Canada, the United States, and other countries.** | |
| **Raise public awareness on youth mental health issues** | Dialogue to create awareness and have an informed public influence policy makers.<br><br>Fight stigma through the holistic education of front-line workers.<br><br>Move away from using the term "mental" health, which lends itself to |

| Objectives | *Activities* |
|---|---|
| | stigmatization. |
| **Build the economic argument** | Bring economists to the table to show the return on investment (e.g., Jim Heckman at the University of Chicago has made compelling arguments and evidence of economic benefits also exists from Australia). |
| **Engage youth in a dialogue on mental health programs and services** | Create an international dialogue with youth to explore how youth with mental health issues are involved in their communities and how young people are involved in policy and service development.<br><br>Build on the US policy platform for youth engagement. |

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## Notes

[1] Established by an act of Congress in 1968, the Wilson Center is an official living memorial to President Woodrow Wilson. As both a distinguished scholar and a national leader, Wilson felt strongly that scholars and policy makers were "engaged in a common enterprise." Within the Center, the mission of the Canada Institute is to increase knowledge about Canada and its relations with the United States among US policy makers and opinion leaders.

[2] Estimates in Canada and the United States suggest that up to one in five young adults (14% to 20%) suffer from a diagnosable mental health disorder, and that several more cases go undetected (Waddell and Shepherd, 2002).

[3] The United Kingdom (2009); European Union (2009); Australia (2008), and other countries have also placed mental health issues at the forefront of recent health policies.

[4] While caution should be exercised in setting firm age limits around the transition to adulthood, its onset can generally be understood to begin in the mid to late teens, with a gradual increase in individual rights and responsibilities consistent with legal, policy, and social structures (such as school leaving and age of majority). Its end is signalled by a gradual gain in independence and long-term commitment to life choices including education, employment, and household composition.

[5] We use the term “Indigenous” inclusively to refer to members of First Nations, Status and non-Status Indians, Métis, and Inuit peoples in Canada, and Native Americans in the United States, recognizing in doing so that many people prefer the terms that are specific and traditional to their communities.

[6] The concept of scaffolding was central to the roundtable discussions on risk and resilience, and the determinants of health. It is described in more detail in sections 3 and 4.

[7] Roundtable participant quoting Kinark (2002).

[8] British Columbia was the first province to establish a province-wide child and youth mental health plan in 2003. It covers youth up to the age of 19.

[9] For additional information on the services provided by the Ontario Ministry of Health and Long-Term Care see <http://www.health.gov.on.ca/ >

[10] Quebec has not endorsed or expressed support for the Commission, based on its view that the Commission impinges on an area of provincial jurisdiction and that existing mechanisms could accomplish much of what the Commission is doing.

[11] The components of the Policy included advocacy, promotion, prevention, treatment, and rehabilitation. Its major underlying principles included protecting consumers’ rights, setting national service standards, mainstreaming mental health services with general health services, better integrating in-patient and community mental health services to ensure continuity of care, and linking mental health services and other social and disability services.

[12] These statistics were brought to light by many roundtable participants, including Dr. Ann Masten, Dr. Patrick McGorry, Dr. Ron Dahl, and Dr. Simon Davidson.

[13] Roundtable participants observed that sometimes this results in an escalated use of medication for management of behaviour, rather than understanding it. In part due to the lack of tolerance for behaviour that deviates from the norm, medication is used as a way for families and schools to control or manage unusual behaviour in institutional settings.

[14] For additional information on this phenomenon in Canada, see Beaujot and Kerr (2007).

[15] One roundtable participant discussed how children in the United States have been expelled from preschool for “behavioural disorders.”

[16] Refers to a “youth” versus “adult” environment and culture.

[17] At time of printing, there had already been Canada-US collaboration around the 2009 Children’s Mental Health Awareness Day.