Policy Revue of Early Intervention:

Mental Health Care for Children and Youth

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**Part A: Policy Introduction**

Early intervention was introduced as a health policy to address funding for children and youth experiencing coping limitations and mental health stressors, and is a health policy that provides health care services in a person’s early years through integrated community services and educational facilities (Canada et. al, 2006) and introduced to offset the effects and costs of long-term disability due to mental illness and related functional difficulties (Wadell, Shepard 2002). Support for early intervention was established over a decade ago within BC through provincial research based on local and national concerns for the growing need for mental health services dedicated to children and youth (Wadell, Shepard 2002). Similar research was promoted federally in 2006, as statistics gleaned in BC typified a national mental health crisis of service delivery (Canada et al, 2006). Early intervention is a health care policy promoted to limit mental health crises in maturity and save future health care dollars (Canada et. al, 2006).

British Columbia has lead the way for national policy development on health care services to children and youth (Davy 2009). As a result of inquiry into mental health services for children, The British Columbia Ministry for Children and Families (BCMCFD) prepared a report outlining the need for service and research for service implementation (Wadell, Shepard 2002). The findings of this research concluded that within BC, 140,000 children and youth were limited by clinically significant and common disorders including; anxiety, conduct, and depressive disorders, as well as early psychosis as described by Ehmann, Yager, and Hanson (2004), in another BCMCFD report. These reports describe these disorders as causing significant distress and social spectrum impairment, resulting in challenges at home and school as well as in the community and with peers (2002, 2004). The prevalence of mental illness amongst BC’s children “topped all other health problems in terms of the number of affected and degree of impairment” (Davy, 2009 n.p.).

Denise Day outlines the process of gaining political support for policy change within BC, in her series titled, *One In Five: Canada’s Crisis In Children’s Mental Health* (2009). Findings prepared by BCMCFD researchers were discussed with mental health groups, educators and school administrators as a means of lobbying support and expansion of ideas around ways to introduce integrated mental health care within day care and school settings. The combination of support from politicians and family support groups ensured that BC’s child and mental health plan was approved in 2003, and given $65 million in funds toward increasing service provision towards children and youth (Davy, 2009).

During the 2006 Parliamentary Standing Committee on mental illness and addiction services in Canada, a policy consensus was forwarded that reflected Canadian, and international evidence for enhanced support for transforming delivery of mental health services (Canada. Parliament. Senate. Standing Committee on Social Affairs, Science and Technology 2006). The Canadian Parliamentary Senate Standing Committee on Social Affairs, Science and Technology (2006) report indicates that consensus was established for the direction of mental health reform and for determining delivery systems for improving mental health services throughout the country. Within this consensus it was determined that services for children and youth must be a priority for service transformation, as the majority of mental health issues affecting Canadians are present during childhood and adolescence. The committee supported evidence that children and youth are vulnerable to the development of mental health issues, but is also heavily affected by treatment when services are provided in an integrated and supportive system that includes family and educational involvement (Canada et. al, 2006). The report included evidence that early indicators of distress are present within 15% of young Canadians, and require immediate supports (Canada et. al, 2006).

The policy of early intervention is a guide to action, and a framework designed to deal with problems that impair global and lifelong functioning for young people and their families (Pal, 2006). The process for early detection and service directed at youth and children experiencing mental health issues has been fragmented and underfunded, causing delays in treatment. Wait lists for support and services have fuelled chronic and distressing stories of suicide and violence amongst Canada’s young population and formed a tragic focus for policy change as families try to cope with the pervasive effects of loss and grief due in large part to lack of services (Davy 2009). Locally the tragic youth slaying of Reena Virk in the fall of 1997, focused attention on the crisis and need for improved services for youth. Her story of a troubled youth in the foster care system, murdered and discarded by a group of youth in Victoria, fixated national attention upon the growing issue of youth violence (Batacharya 2004). The need for a framework to address growing child and youth mental health was well established heading into the twenty first century, and the forum for service need well established.

**Part B: Early Psychosis Intervention**

The World Health Organization recognizes active psychosis amongst the most debilitating health conditions, evidenced by a decreased life quality and diminished life expectance and higher risk for other mental and physical health conditions (BCMHS 2010). The initial experience of psychosis is referred to as a ‘first episode’, an extremely distressing and potentially debilitating experience for those affected. Early Psychosis Intervention has been implemented to address psychosis after initial episodes through intensive services to both clients and families as necessary for a period of at least three years. The British Columbia Ministry of Health Services (BCMHS) standards and guidelines highlights the benefits of EPI (2010), stating:

When EPI is done right the results are impressive.

Early psychosis intervention programs have been shown to decrease

duration of untreated psychosis, decrease hospitalization, decrease police

involvement in admissions, lower medication use, improve functional

outcome, lower relapse rates, improve treatment adherence and lead to

greater patient satisfaction. These programs have been shown to be cost-

effective in other jurisdictions. (p. 6)

Watching for signs of psychosis is an important function of EPI as symptoms are often misinterpreted as typical for teenage behavior, or mistakenly attributed to substance use (Anonymous 2003). Psychosis and related conditions detected in late adolescence and early adulthood according to BC Mental Health Services, may limit the individual’s opportunities for vocational, educational and social progress (2010). Early identification and ensuing diagnosis and treatment are fundamental principles within health care as a means of minimizing the decline, and societal costs, as well as the burden of suffering associated with illness. However, mental health has been an exception to this premise with sufferers and their families, languishing without diagnosis, treatment or hope. This lack of early assessment and effective treatment of psychosis has lead to social marginalization and stigma for those dually impacted by their illness with little hope of recovery. This situations has improved in the last decade as researchers, clinicians, families and policy makers are listening to those affected by early psychosis. EPI has been embraced and gained empirical support as a means to address early onset psychosis as a respectful and hopeful means of offering; awareness, assessment, diagnosis and treatment (2010).

British Columbia has supported the EPI approach since 2000, as a result of interagency and inter-ministerial initiatives that funded and developed stakeholder interest in pilot projects designed to introduce clinical EPI services as a model for the entire province (BCMHS 2010). Four years after the introduction of EPI services, the BC Schizophrenia Society commissioned a survey to assess the scope and practices of EPI service, their findings revealed variability I the structure of EPI, and an greater inclusion of best practices when compared to service provided by traditional mental health teams (BCMHS 2010) In 2003 B.C.'s child and youth mental health plan was approved given $65 million, which allowed them to double the number of clinicians province wide, these funds were intended to support service for early intervention programs for children consistent with the model for EPI and to facilitate transitions between services for youth and supports for adults (Davy, 2009).

As a means of making practice out of policy, standards and guidelines were established to ensure that EPI service providers adhere to evidence-based practice and practice consistency in service delivery (BCMHS 2010). Guidelines are directed toward Health Authorities and related community based programs, to ensure that client’s receive timely, effective and respectful support during the initial year of recover after the onset of a psychotic episode. Related programs operated by other government ministries such as MCFD and the Ministry of Education are integral in advancing EPI guidelines as a continuum of integrated programs and services (BCMHS 2010). This continuity is essential for early education in recognizing symptoms, as well as minimizing stigma and integrating efficient service, continuity between ministries is particularly relevant given the developmental nature of the onset of psychosis (Canadian Psychological Association 2013).

Links between service ministries are consistent with guidelines for service within EPI standards. The underlying philosophy being that bridging child/youth and adult services would provide consistency and levels of compliance with clinical guidelines, follow up surveys conducted in 2008 revealed inadequacies in establishing unified service organization, and implementation. These findings established the need for a cohesive set of standards to ensure accountability and consistency in planning and evaluating service, to maximize service delivery to clients. Integration of service and continuity were determined as ongoing challenges face by IEP (BCMHS 2010).

As a result of the Child and Youth Mental Health Plan established in 2003, funding was provided for programs to address early mental health concerns. Friends, a childhood anxiety-prevention program implemented in the BC school curriculum, is the first of its kind in Canada. The purpose of the program is to introduce concepts of stress reduction, but also to address awareness of the early indicators of mental health issues and introduce preventative strategies early and referral for early intervention as continuity for EPI. Funding was also given to a parent support group, Families Organized for recognized Care Equality, or FORCE as a means of promoting a parental voice through organizing chapters across the province and establishing a 1-800 information line for parents. The aboriginal community was provided $10 million in funding for the development culturally appropriate child and youth services (Davy 2009).

Youth experience the greatest numbers of first episode events, yet according to BCMHS (2010) are the most challenging population for service provision, it is determined that most mental health and addictions services are failing youth (BCMHS 2010) (Davy 2009). BCMHS report that youth responses to mental health and addictions services indicate that traditional service delivery is stigmatizing, insensitive and pessimistic as evidenced by the majority of youth dropping out of service within 12 months. The reasons for the difficulties related to effective youth treatment include; lack of former experience and trust in the medical system as most youth have had little to do with medical interventions, increased sensitivity to psycho active medication side effects, and recreational drug use/abuse. Minimum standards are recognized that address service concerns and include referrals for service are not rejected because of a co-occurring disorder such as substance abuse. Effective EPI work with youth de-emphasizes diagnosis and emphasizes choice, education and life management through services such as cognitive behavioral therapy. Services are most effective when delivered in a non-clinical environment and are facilitated in the home or community of the youth in an outreach fashion. Medications are recommended after a psychosis threshold is established, initially prescribed at low dosages and supported through education to reduce the alienating responses to side effects BCMHS (2010).

In BC a hindrance to EPI is the conflict between committed community treatment CCT and EPI. CCT is based on the principle of least restrictive setting, however BC has a pre-condition of patient detention or multiple lengthy hospitalization for referral to community treatment, a condition that thwarts the efforts of early intervention (Graya, OReilly 2005). This conflict highlights the emphasis for initial management of early psychosis and is addressed in the EPI minimum standard which determines that referrals for service be accepted from both hospital and community, this standard ensures that CCT and EPI are facilitated in conjunction when applicable (BCMHS 2010).

The scope of the practice of EPI is extensive and integrates evidence-based services such as client-centered care, and community delivered resources. The philosophy of respect for an individualized and integrated approach to care is introduced early to address growing mental health issues related to minimizing depression, anxiety and recognizing early psychosis. BC has been a national leader in defining and funding early intervention strategies, and recognizing the acute need for EPI if psychotic episodes are to diminish in the future.

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