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## **Children First: It's Time to Change! Mental Health Promotion, Prevention, and Treatment Informed by Public Health, and Resiliency Approaches**

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# Children First: It's Time to Change! Mental Health Promotion, Prevention, and Treatment Informed by Public Health, and Resiliency Approaches

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## Abstract

Although the importance of healthy mental development in children and youth is not disputed, the mental health needs of far too many Canadian children are being ignored. Within the context of recent federal and provincial calls for systemic reform of the mental health care systems for children and youth, we underscore the necessity for ongoing innovation, development, education, and evaluation. This article describes our aims to establish demonstration and research sites focused on promising frameworks that draw from systems of care, public health, and resiliency approaches.

## Résumé

Même si l'importance du développement saine de la santé mentale parmi les enfants et les jeunes n'est pas contestée, les besoins de la santé mentale de bien trop d'enfants canadiens sont ignorés. Dans le contexte des appels fédéraux et provinciaux récents pour la réforme des systèmes des soins de la santé mentale pour les enfants et les jeunes, nous mettons en évidence la nécessité pour l'innovation, le développement, l'éducation et l'évaluation continu. Cet article décrit notre but d'établir des sites de recherche et de démonstration centrés sur les cadres des procédures pour la santé publique prometteurs qui sont tirés des approches de résilience.

## Keywords

mental health, children and youth, systems of care

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Mental health starts in childhood and is fundamental to child health, well-being, and active participation in school, community, social, and family networks and leisure activities. Yet, mental health disorders affect 15% to 20% of Canadian children and youth, representing the single most common health problem affecting nearly 1,000,000 young Canadians (Kessler et al., 2005). These mental health disorders are present when we count many of the challenges and losses experienced by Canadians, including suicide, poor education and employment outcomes, compromised well-being, involvement in the criminal justice system, and family breakdowns (Gould, Greenberg, Velting, & Shaffer, 2003; Huang et al., 2005; Tolan & Dodge, 2005; Trocmé et al., 2008). The cost of these losses is enormous, with mental health identified as the biggest drain on economic productivity in the workplace and costing Canadians over CAD\$14 billion a year (Stephens & Joubert, 2001). Even more staggering is the finding that only about 20% of Canadian children and youth identified with a mental health disorder ever receives mental health care within our current mental health care system (Waddell, Offord, Shepherd, Hua, & McEwan, 2002). It is time to change how we deliver mental health care. This article brings together research and practice issues viewed through the lenses of systems of care, resiliency approaches, and public health policy frameworks to the delivery of children's mental health services, value-driven models that places the child in the foreground of the well-being landscape.

## **Prevalence of Mental Health Disorder Among Children**

The prevalence of mental health disorders among children and youth has been discussed by Flett and Hewitt (see this issue), but in examining children's mental health specifically in the context of school and education, we look to a study of school administrative leaders in Ontario, where researchers Santor, Short, and Ferguson (2009) report that (in order) anxiety and mood problems (including a sense of helplessness, low self-esteem and suicide), conduct problems, oppositional behavior and violent outbursts and substance use were identified as the four highest priority student mental health issues. Alongside this list appears a most troubling observation, particularly given the amount of time children spend at school: 67% of the administrative leaders rated teachers as being not at all, or only a little, prepared to identify and manage student health needs.

There is compelling evidence that directs us to both the short term impact and longer term consequences of children's mental health: First, evidence suggests that academic performance in children is lower where higher levels of anxiety and depression are present, and mental health is related to school dropout in Ontario at a cost of CAD\$1.9 billion per year (Owens, Stevenson, Hadwin & Norgate, 2012); second, it is critically important to note that research has identified that among young adults with a mental health diagnosis, 70% can identify that their disorder had an onset in childhood (Kessler et al, 2005).

## The Cost of Children's Mental Health Services

The cost of caring for our children and youth with mental health disorders has been examined in the USA by using the MEPS-HC, a national longitudinal study, and the annual health expenditure for mental health among school aged children was US\$2,224 per child (Davis, 2012). Further, and using the same data, Roemer (2011) reports that treating mental health is the most expensive of the top five children's health conditions, exceeding the treatment costs for asthma, trauma, bronchitis, and otitis media.

Looking at the Canadian context, Ontario researchers Eileen Pepler and Murray Bryant undertook a service mapping study in partnership with the Ministry of Children and Youth Services to study the current children's mental health delivery system in southwestern Ontario. The results indicate that across agencies, the cost of treatment for one child with mental health disorders was CAD\$7,312.90 and further, that nearly CAD\$4,000.00, or 54%, was spent on case management. These researchers discuss case management and numerous "hand-offs" and waiting periods and suggest that 71% of all the activities in the service map are considered to be nonvalue added (Pepler & Bryant, 2011).

## Services for Children's Mental Health

The phrase "a paucity of research" is often used in reference to what is known and not known about availability, accessibility, and efficacy of treatment for mental health disorders for Canadian children and youth. What has been identified, however, is that the service delivery system and pathways to treatment for child and youth mental health in Canada, and in Ontario specifically, are costly, highly fragmented, and difficult to navigate for families and children (Shanley, Reid, & Evans, 2008; Pepler & Bryant, 2011). If we are to make positive change, we must pay close attention to the three dimensions of access to care, namely availability, affordability, and acceptability (CIHR-IHDCYH, 2010).

Many families across Canada are engaged in an often isolated and ill-supported battle to address their children's mental health problems. Epidemiological studies place estimates of the prevalence of mental health disorder among Canadian children and youth at about 15% (or nearly one million young people), and the majority—about 75%—do so without receiving treatment through our current health care systems (Waddell et al., 2002; McEwan, Waddell, & Barker, 2007). This disparity between need and service has come under more scrutiny with the release of Canada's first national mental health strategy (Changing Directions, Changing Lives, MHCC, 2012) and the recent review commissioned by the Centre of Excellence in Child and Youth Mental Health entitled: *Taking mental health to school: A policy-oriented paper on school-based mental health for Ontario* (Santor et al., 2009).

Considering the demonstrated impact of mental health problems on social, emotional, cognitive, and educational functioning, it is of critical importance that we bring

our resources to bear on the reconceptualization of mental health care for the children and youth of Canada. The connection between mental health and school success (defined here as the number of years of education completed) has been established and examined; most recently researchers such as Alatupa and colleagues (2011) observed, in a longitudinal study of 973 youth over a 10-year span, that early disruptive behavior has long-lasting effects on grades. Depression has been linked with poor text comprehension and memory (Becker, Ellis, Varner, & Moore, 1997; Owens et al., 2012), and research has demonstrated a high rate of co-occurrence between learning disabilities, depression, and anxiety (see, for example, Canadian Council on Learning, 2009).

The need for a comprehensive mental health care system has been identified in both the United States (Tolan & Dodge, 2005) and Canada (Kutcher, Hampton, & Wilson, 2010). In their review on child and youth mental health policy in Canada, Kutcher and colleagues note the “nationally inadequate” mental health services for children and youth in a system where there is currently no national children’s mental health strategy and where provinces or territories have jurisdiction over health care but only a few have policies or plans that specifically address children’s mental health (Kutcher, Hampton, & Wilson, 2010). Looking more closely at both policy and practice conditions that prevent people from accessing mental health care, the Canadian Institutes of Health Research discuss barriers at three levels: (a) Individual-level barriers include stigma, help-seeking behaviors and attitudes, mental health status, parental risk factors, and previous experience seeking mental health care; (b) community-level barriers include geographic location and social location; (c) system-level barriers include funding, wait times, availability of trained personnel, and fragmentation of services (CIHR-IHDCYH, 2010).

In response to the need for a national strategy for child and youth mental health, Evergreen: A Child and Youth Mental Health Framework for Canada has been developed under the guidance of Dr. Stan Kutcher and Alan McLuckie and from the Child and Youth Advisory Committee of the Mental Health Commission of Canada. The Evergreen Framework was developed through extensive participation, consultation, and feedback with a wide cross-section of Canadians and internationally and included both professionals and people with lived experience. The resulting guide outlines a set of core values to “inform and shape all child and youth mental health policies, plans, programs and services across Canada” (p. 6) and includes human rights; dignity, respect and diversity; best available evidence; choice, opportunity and responsibility; collaboration, continuity and community; and access to information, programs, and services. The framework also includes strategic directions that are organized into four categories: promotion, prevention, intervention and ongoing care, and research and evaluation (Kutcher & McLuckie, 2010).

Increasingly, schools are viewed as a potential part of a system in support of child and youth mental health service. Ontario’s Education Minister, Laurel Broten, supported this in her recent address at the People for Education Conference (2011) with her pledge to make the response to child and youth mental health within a school context a significant part of her tenure as the Education Minister. The Centre of

Excellence in Child and Youth Mental Health commissioned a recent review entitled "Taking mental health to school: A policy-oriented article on school-based mental health for Ontario" (Santor et al., 2009). Canada's Mental Health Commission (2011) has identified school-based mental health as a major target of service development in our nation's future systems of care. The Canadian Policy Network has identified that the strongest return on investment was for children's mental health (including emotional and behavioral disorders) in schools (Roberts & Grimes, 2011). In an earlier article in this issue, Kutcher and Wei (2013) present the preliminary evaluation of an extensive school-based mental health program that features collaboration and engagement with community, health care, families, teachers, and youth.

These developments place an understanding of the mental health needs of children and youth in the context of education as a priority. In fact, the recent report by Santor and colleagues (2009) position mental health as an important factor for students—14% of school dropouts are related to mental health disorders; children with mental health problems are absent 40% more school days than their peers, and mental health problems are connected with underachievement. Education plays a gate-keeping role in our society and success in education is connected with success in employment, financial independence, and healthy living. In their article on mental health programs in education, McLennan, Reckford, and Clarke (2008) observed that "schools may be the most frequent site of service delivery and receipt and thus serve as the de facto mental health system for children" (p. 122). It is of critical importance that we consider the integration, and not merely colocation, of services for children, youth and families and schools as not just an adjunct to a mental disorders treatment delivery system but an integral part of systems of care.

## Demonstration and Research Sites

Finding ways to improve the mental health of our children, youth, and families is becoming an increasing priority for all Canadians. Decision makers in both the public and private sectors have been actively exploring ways to accomplish this goal, as seen in the recent release of a Mental Health strategy for Canada and emerging provincial documents (e.g., Ontario, *Transformation of the Community-based Child & Youth Mental Health System*; Alberta, *Children's Mental Health Plan for Alberta*; Saskatchewan, *A Better Future for Youth: Saskatchewan's Plan for Child & Youth Mental Health Service*). As noted by Ham, Hunter, and Robinson (1995), the dangers for a community of implementing health policy changes and practices in the absence of demonstration and research are substantial. It is their contention that a continued *independent source of ideas and funding* to support research and analysis, along with effective mechanisms for dissemination and implementation of the results of research into policy and practice, are an essential part of a strategy for enhancing the well-being of all citizens. The Director General of the *World Health Organization* (WHO) and the *Alliance for Health Policy and Systems* echo these sentiments and call for promoting capacity building and the dissemination of research to inform policy,

implementation, and program development (see Hanney Gonzalez-Block, Buxton, & Kogan, 2003).

Our vision is to create research and demonstration sites specifically designed to address the multiple and interrelated mental health promotion, prevention, and treatment service needs of children, youth, and their families. Using knowledge generated from our research and demonstration sites, we will advise, partner, and serve as “change agents” and dissemination outlets for recent, current, and planned value-driven mental health care strategies. We seek to provide accelerated effectiveness and outcomes research addressing the consequences of mental health care policy, implementation, and practices with respect to diverse issues including financial sustainability; effectiveness information; dissemination and translation strategies; evidence gaps; models for prevention, promotion, and treatment; and, new evaluation methodologies. We also aspire to encourage research focusing on the spread of promising practices sensitive to vulnerable and disenfranchised populations. Our success will be highly dependent on partnering with colleagues within a research-intensive university well-versed in research methodologies, as well as policy makers, health care providers, and communities and in addressing questions that are informed by the information needs and inputs from various stakeholders. A critical by-product of our work will be exemplary service that will be provided to children and families within our demonstration and research sites.

In the following sections, we review the research literature to identify contemporary models and approaches to the delivery of children’s mental health promotion, prevention, and treatment services that have promise for addressing the gaps seen within the Canadian children’s mental health system. We hope to use this literature to inform our efforts to develop research and demonstration sites that aim to achieve systemic reform in the children’s mental health system.

## **What Can We Learn From the Americans?**

Within the context of a mental health crisis that is continuing to deepen as a result of budget cuts and a global economic crisis, it seems logical to ask whether we can learn anything from the United States about delivering appropriate and effective mental health care to children (see Honberg, Diehl, Kimball, Gruttadaro, & Fitzpatrick, 2011). Yet, we must recognize that the United States is the number one producer of publications related to science and a world leader in medical innovation (Matthew Herper in Forbes, 2011), including innovative solutions for fundamental system reform around children’s mental health. Given our primary concern with enhancing mental health care for children in Canada, we believe that we must be informed by and draw lessons from the extensive theoretical paradigms, research, and practice base that have defined the children’s mental health movement in the United States if we are to achieve significant improvements in access, quality, and efficacy of care for children in Canada. At the same time, we fully recognize that our unique political and social culture, demographics, and form of government will ultimately shape any



solution for Canada. Notwithstanding this cautionary note, we have identified several approaches that have worked well in the United States and could be adapted to the unique context of Canada.

Perhaps the most significant contextual and structural factors differentiating Canadian and American health care (including mental health) relate to funding mechanisms. Although Canada has what is generally considered a “universal” health care system, the United States has a mixed public–private system. Recent data show that about 70% of health care spending in Canada is financed by government versus 46% in the United States. In the United States, direct government funding of health care is limited to Medicare, Medicaid, and the Children’s Health Insurance Program, which cover eligible senior citizens, the poor, persons with disabilities, and children. For everyone else, health insurance must be paid for privately, and approximately 6% of American residents are uninsured at any one time. In America, states hold primary responsibility for mental health delivery while the federal government holds regulatory and funding authority for Medicaid and block grant funding to the states. Private health care insurance, out-of-pocket payments made by individuals, and other sources supplement funding to mental health services (Guyatt et al., 2007; Nair, Karim, & Nyers, 1992; OECD Health Data, 2008; Szick et al., 1999). In Canada, the delivery of mental health services is largely a provincial responsibility, although the funding and regulation of aspects of delivery may be shared between federal and provincial governments (Kirby & Keon, 2004).

Unfortunately, there is a dearth of studies comparing mental health utilization rates between Canadian and American children. Research examining psychiatric disorders in persons aged 15 to 54 years and utilization in the United States and Ontario challenges the assumption that the universal health insurance plan in Ontario promotes greater access to mental health services than is available in the United States. For example, results suggest that the time period separating psychiatric disorder onset from the first treatment contact in the United States is not dramatically different from that in Ontario (Guyatt et al., 2007; Katz et al., 1997; Nair et al., 1992; OACD, 2012; Szick et al., 1999). Retrospective data indicates that in both countries, children experience longer delays in receiving treatment because of their dependence upon adults to initiate a referral. Interestingly, research has found that the creation of the Ontario Health Insurance Plan coincided with a trend toward longer delays in mental health treatment in Canada than in the United States.

In contrast, reports indicate that low-income respondents in the United States are more likely to report a financial barrier to use of mental health services than low-income respondents in Canada. Within this context, it is important to underscore that need is higher in the United States than in Ontario, a finding consistent with other evidence of better physical and mental health in Canada than in the United States (Olfson, Kessler, Berglund, & Lin, 1998; Vasliadis, Lesage, Adair, Wang, & Kessler, 2007). What seems consistent across both countries is that presumably curable children with early onset disorder are, in effect, ignored by the treatment systems. Reports from both countries indicate similar issues in the child mental health system:



fragmentation of services; categorical program funding; limited accessibility and availability; agency driven services; funding issues; ineffective and inadequate services; and so forth (e.g., Office of the Provincial Advocate for Children and Youth for Ontario, 2011). What has differentiated the two countries is the earlier entry of the United States into the search for innovative solutions for fundamental system reform around children's mental health.

In 1982, the plight of American children and adolescents with serious emotional disturbances was brought to the forefront with the publication of Jane Knitzer's report, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*, in which policy and program disconnects in the delivery of mental health services were solidly documented. This report also described innovative community-based mental health initiatives that were making headway in improving mental health care for children. In response, the Child and Adolescent Service System Program (CASSP) of the National Institute of Mental Health undertook an initiative to develop and describe a model system of care for children with serious emotional disorders and lead the way to Stroul and Friedman's (1986) widely read monograph, *A System of Care for Children and Youth with Severe Emotional Disturbance*. Over the next number of years, there was an explosion of activity in the United States related to systems of care development and an increasing number of communities made substantial progress toward the development of community-based services for children with serious emotional disturbance (Stroul, 1993).

In their 1986 conceptualization of a system of care, Stroul and Friedman described a values-based organizational philosophy that focuses system change on building collaboration across child-serving sectors, families, children, and youth for the purpose of improving access to an expanded array of coordinated community-based services for children with serious emotional disturbances (Stroul, 1993; Stroul & Friedman, 1986) unencumbered by multiagency jurisdictional fragmentation (Hodges, Ferreira, & Israel, 2012). Importantly, their early work codified a set of values and principles related to the organization and delivery of services that essentially set directions for child- and family-centered services within a community-based network (i.e., access to a comprehensive array of services, individualized care where needed, services provided in the least-restrictive environments, full parent participation in decision-making, fully integrated services, case management, early identification and treatment, seamless transitions across levels of service, effective advocacy, and culturally relevant delivery; Stroul & Friedman, 1986).

The conceptualization of systems of care is implicitly anchored within developmental, bioecological, and systems theories of childhood psychopathology. Ultimately, a system of care recognizes that children's problems reflect unique interactions between intraindividual difficulties and environmental conditions. Treatment must therefore address conditions in the family, school, and neighborhood, as well as within the child. This requires a system with a diverse set of interventions and the capacity to coordinate multiple services (Saxe, Cross, & Silverman, 1988) (e.g., mental health services, social services, educational services, health services, vocational services,

recreational services, and operational services, including case management, self-help and support groups, advocacy, transportation, legal services, and volunteer programs). These complex interactions are explicitly recognized within a system of care through its focus on the child and his/her family and community; a breadth of interventions based both within and outside a child's family; situating interventions within the community settings that form a child's environment; interdisciplinary approaches involving coordinated formal and informal efforts among diverse service systems; and, a strong emphasis on prevention to lessen the long-term suffering and cost of childhood mental health disorders (Saxe et al., 1988).

Services within systems of care are typically provided by both formal and informal agencies and organizations in both the public and private sectors; however, what is unique within systems of care is the nature of their relationship; it is defined by their interdependence and shared values and principles. As such, the effectiveness of any one component is related to the availability and effectiveness of the others. Success is entirely dependent on attaining a balance between the components along the continuum of care and the enmeshment of services in a coherent, well-coordinated system (Stroul & Friedman, 1986).

A hallmark of systems of care has been the development of individualized treatment plans. These plans are often realized through a participatory planning process called "wraparound" (Burns & Goldman, 1998; Burns et al., 1995; Eber, 1996, 1997; Eber, Sugai, Smith, & Scott, 2002; VanDenBerg & Grealish, 1996). Wraparound aims to bring family, youth (where appropriate), members of the natural support system, and members of the formal service system together to develop plans that reflect a comprehensive focus on strengths and needs of families in multiple life domains. Such treatment plans frequently involve family choice of services and providers and are designed to be culturally competent, coordinated by a case manager, and involve multiple components (Friedman & Drews, 2005, p. 3). Careful and systematic application of the wraparound process can increase the likelihood that appropriate supports and interventions are adopted, implemented, and sustained (Burns, Schoenwald, Burchard, Faw, & Santos, 2000; Eber, 1997, 1996) thereby leading to improved behavioral outcomes for children and youth (Eber, Sugai, Smith, and Scott, 2002).

Today, the systems of care initiative represents the largest federal American investment that targets children with mental health problems. More than US\$104 million in federal funding annually supports development through the Comprehensive Community Mental Health Services for Children and Families program. A 2008 report indicated that 94% of states have incorporated the systems of care philosophy and values for children and youth, particularly those with serious emotional disorders (Cooper et al., 2008). As of 2008, the Substance Abuse and Mental Health Services Administration had already funded community grants totaling more than US\$1 billion to implement systems of care within local children's mental health systems (Pullman, Heflinger, & Mayberry, 2010). Despite what may seem as "grand efforts," these sites serve fewer than 70,000 of the 1.3 million children using publicly funded or delivered mental health services in the United States (Knitzer & Cooper, 2006).

## Early Research on Systems of Care

To date, evaluation studies of systems of care that define outcomes of interest beyond mere symptom reduction are surprisingly rare (Hoagwood, Jensen, Petti, & Burns, 1996). Early research summaries focusing on the effectiveness of systems of care suggest that overall, they provide high quality, more appropriate, and cost-effective care realized through an expanded array of services; an individualized service approach, which emphasizes the involvement of families in all aspects of the planning and delivery of services; a variety of interagency structures for system-level coordination, interagency case review and problem resolution; and, case management mechanisms to ensure coordination of service delivery at the client level (Stroul, 1993). Other research and evaluation results have demonstrated that systems of care enhance the lives of children, youth, and families, including improvement in clinical and functional outcomes, increases in behavioral and emotional strengths for both youth and caregivers, reduction in suicide attempts, improvement in school performance and attendance, fewer contacts with law enforcement, reduction in reliance on inpatient care, and more stable living situations (Manteuffe, Stephens, Sondheimer, & Fisher, 2008). Systems of care have had a positive impact on the structure, organization, and availability of services and are a cost effective way of delivering home and community-based services (Burns & Goldman, 1998; Gruttadaro, Markey, & Duckworth, 2009; Hoagwood & Hodges, 2003; Knitzer & Cooper, 2006; Manteuffe et al., 2008; Stroul, 1993).

Although there has been a growing research base to support the efficacy of systems of care, their development has not been without challenges. Explorations report the need to take more intentional and specific steps to make operational and sustain them through legislation and regulation, practice standards, and strategic planning (Cooper et al., 2008). Noteworthy have been issues centering around the implementation of policies and strategies to support culturally- and linguistically-competent services and systems, lack of transparency and accountability which pose major obstacles to furthering strong fiscal structures, and lack of infrastructure-related supports due to serious gaps in terms of mental health services available to children and families (Cooper et al., 2008; Friedman & Street, 1985). More specific challenges have been referenced by other researchers. Knitzer and Cooper (2006), for example, report that despite increased service capacity among systems of care sites, a failure to integrate decision making at the system level and lack of capacity for continuous self-appraisal at the care-unit level have compromised continuous quality improvement, the adoption of effective interventions, and the infusion of culturally competent practices. Underutilization of technology at all levels of the delivery system are barriers to the timely exchange of information, decision-making processes, and outcome assessments and underscore the need to implement state-of-the-art technology systems that permit the collection of information that allows for the management of a child's needs over time, as well as the assessment of the effects of interventions (see Showstack, Lurie, Larson, Rothman, & Hassmiller, 2003). Other research points to a lack of

understanding regarding the processes underlying systems change (Hernandez & Hodges, 2003; Hodges et al., 2012) and highlights the importance of implementing clear, comprehensive, and consistent expectations, policies, and regulations.

Perhaps the most bothersome revelation relates to inconclusive findings regarding clinical changes (i.e., symptom reduction) resulting from organizational change strategies (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Tolan & Dodge, 2005). For example, one early study comparing outcomes in a systems of care with a traditional service delivery model reported that although positive system-level outcomes were achieved (e.g., access to care, amount of care, family satisfaction), there was no significant outcome differences between the system versus traditional sites (Bickman, Lambert, Andrade, & Penalosa, 2000). Limited translation and application of evidence-based practices in a systems of care, lack of fidelity in the implementation and delivery of evidence-based practices, variability in “experimental” treatment settings (including characteristics that affect the adoption of efficacious treatments), practical barriers that impede the integration of evidence-based interventions into practice, a tendency for professionals to be influenced by clinical judgment rather than by research; and, lack of training have all been cited as explanatory for these findings (Friedman & Drews, 2005; Hoagwood et al., 2001; Tolan & Dodge, 2005). Hoagwood et al. (1996) caution against employing clinical outcomes as a singular indicator of the success of systems of care and argue for the use of an interactional model of outcomes that takes into account critical contextual relationships and presents a more comprehensive view of the impact of care. It is their contention that valid assessments of the effectiveness of care necessitate conceptual and pragmatic linkages of multiple outcomes, reflecting interwoven levels of impact at the individual, familial, social, and systemic level (i.e., symptoms and diagnoses, functioning, consumer perspectives, environment, and systems; Hoagwood et al., 1996).

## The Next Generation of Systems of Care

Despite laudable efforts to implement systemic changes to the American mental health system over the twenty years following Knitzer’s call for structural reform, Tolan and Dodge in 2005 noted that the gap between the mental health needs of children and the supports and services available to meet those needs had become even larger. In their seminal article, *Children’s Mental Health as a Primary Care and Concern*, they argue that “it is time to declare children’s mental health to be a primary concern that justifies interventions and policies” (p. 602). Four *interdependent emphases in action and policy* are identified: (a) systems must be reformed to ensure access to appropriate, effective, and coordinated treatment when a diagnosable condition can be documented; (b) effective, scientifically supported, preventive interventions for children who exhibit signs of risk must become regular, integrated, and substantial components of a child mental health system; (c) capacity to serve periodic and subclinical-level child mental health needs must be dramatically increased through training, support, and a set of expectations that promote mental health issues; and,

(d) infrastructure and policies to promote and support healthy psychological development as integral to health and development must be set in place. Another four *principles intended to guide a comprehensive system* are presented by Tolan and Dodge (2005) and include (a) ensuring that *all* children with mental health needs have access to appropriate services by promoting greater recognition of mental health issues, shifting services from provider- or sector-based organizations to child- and family-based organizations, overcoming stigma, and, ensuring appropriate and timely responses; (b) providing access in primary developmental settings following the systems of care approach to organizing child mental health services and ensuring that services are child- and family-centered, family members are active partners in decision making, and services are developmentally appropriate and incorporate a wraparound approach; (c) ensuring that evidence-based mental health practices are integral components in all primary care settings; (d) broadening models to include mental health promotion as well as prevention; and, (e) attending to cultural context and influences.

Comparable recommendations were forthcoming from the National Center for Children in Poverty (Cooper et al., 2008), where characteristics of a next generation mental health system were presented (e.g., flexible funding that allows for a rapid response to emerging knowledge and research-informed practice; dedicated funding for health promotion, prevention, and early intervention; implementation of core systems of care values; emphasis on the elimination of disparities based on race/ethnicity, culture, language, and age; increased work force capacity and competence; data-driven clinical and administrative decision-making; increased attention to functional outcomes; and, an integrated delivery system) (p. 6).

In 2011, Stroul and Friedman undertook the task of expanding the framework for systems of care in five core areas (i.e., Implementing Policy, Administrative, and Regulatory Changes; Developing or Expanding Services and Supports based on the Systems of Care Philosophy and Approach; Creating or Improving Financing Strategies; Providing Training, Technical Assistance, and Coaching; and, Generating Support). Within each of these core strategy areas, a number of more specific substrategies were identified. By way of example, specific substrategies for implementing policy, administrative, and regulatory changes included establishing an organizational locus of systems of care management and accountability at state and local levels; developing and implementing strategic plans; and, developing interagency structures, agreements, and partnerships for coordination and financing. Strategies for generating support included establishing strong family and youth organizations; generating support among high-level policy and decision makers; using outcome data; generating support through social marketing and strategic communications; and, cultivating leaders. Of all the strategies explored through their study, the authors found that the most significant and effective strategies involved requiring providers mandate the use of the systems of care approach, inserting systems of care language in regulations, and developing provider manuals and practice protocols based on the systems of care approach. Other systems of care strategies included establishing a clear locus of accountability; providing training on the approach; expanding the array of services

and supports; expanding an individualized, wraparound approach to service delivery; expanding family and youth involvement in services; creating and supporting strong family organizations; and, increasing the use of insured financing.

## **Effective Financing Strategies for Systems of Care**

Creating financing mechanisms to strategically support the infrastructure and services comprising systems of care has proven to be one of the most significant challenges to effective implementation. Yet, the importance of fiscal stability is undisputable. For example, the World Health Organization (2003) argues that mental health financing is one of the most powerful tools through which policy-makers can develop and shape quality mental health systems. In its absence, mental health policies and plans remain in the realm of rhetoric and good intentions (p. viii). Noteworthy are the recommendations made by the World Health Organization, including:

- Financing mechanisms can be used to facilitate change and introduce innovations in systems. Financial and budgetary factors that can encourage the shifting of the balance between hospital and community services include budget flexibility; explicit funding for community services; financial incentives; and, the coordination of funding between ministries or agencies.
- One of the critical ways to reframe financing and develop a resource base is through seed funding for innovative projects and the inclusion of resource development for mental health. One approach to innovation is to create a special mental health innovation fund. This could seed demonstration and evaluation projects, even on a small scale, so as to promote change and quality improvement (p. 3).

The Research and Training Center for Children's Mental Health at the University of South Florida has conducted several 5-year studies to identify critical implementation factors that support effective systems of care, including examinations of financing strategies to support their infrastructure, services, and supports (see Stroul, 2007). Their findings led to a recommendation for a more coherent, effective, and efficient approach to financing the infrastructure and services that comprise systems of care. They argued for a realignment that uses resources from multiple funding streams, maximizing the use of entitlement programs, redirecting and redeploying resources, and improving the management and coordination of resources. A very detailed discussion of effective financing strategies is presented by Stroul, Pires, Armstrong, Pizzigati, & Wood (2008). On a similar note, Knitzer and Cooper (2006) have been outspoken in their call for strategic reformulation of fiscal policy in the United States.

This is an important time for children's mental health . . . but the devil is in the details. Balanced social policy demands that mental health policymakers move beyond the rhetoric of transformation accompanied by piecemeal, often



time-consuming initiatives with limited or no funding or inflexible funding that only tweaks systems at their edges. Policymakers must initiative bold measures based upon new knowledge and continuous self-appraisal. Such reform must fundamentally change the financing structures and must focus on organizational issues in service delivery with an outcome-oriented approach that encompasses promotion of healthy outcomes, prevention of problems, early intervention, and when necessary, more-intensive treatment. (p. 676)

Although a full discussion of child mental health services' funding is not within the scope of this paper, lessons can be gleaned from several countries where emphasis has been placed on strengthening community care alternatives. For example, in New Zealand, efforts have been enacted to cost a plan based on an analysis of the gap between what existed and what was needed. The plan, which places strong emphasis on community-based and comprehensive mental health services, strongly resembles systems of care. As such, it articulates goals that direct primary emphasis to data collection and analysis, coordination of services; empowering individuals and communities to take action on their own behalf; planned priority actions for mental health promotion and early prevention; workforce development; reducing social inequalities related to mental health; and, improving individual and community resiliency skills. In striving to meet these goals, New Zealand has directed almost 70% of its mental health funding to community-based services and recommended that a sustainable funding path be identified for mental health services development consistent with the directions of its mental health strategy. Although not as encompassing in its national strategy, England has tackled the thorny issue of ensuring funding streams that bring services directly to children within the communities in which they live, learn, and play through the amalgamation of different agencies to create a single provider responsible for the broad spectrum of mental health services within each locality. Although neither of the directions taken by New Zealand or England are without their challenges, we believe they provide insight on potential solutions Canadians might consider as we seek to transform the children's mental health "system" (see Kirby & Keon, 2004 for mental health policies and programs in selected countries).

## **School-Based Mental Health**

A parallel movement to systems of care development in the United States in the 1980's involved educational reform designed to enhance outcomes for vulnerable and disadvantaged children and youth, including those youngsters presenting with mental health challenges (Dryfoos, 1996). To better meet the mental health needs of children and provide greater access to multifaceted, comprehensive, and integrated services, advocates called for a restructuring of school-owned services and greater linkages with community resources (Adelman & Taylor, 2000a, 2000b, 2006). Given that schools are second only to families in shaping children's development, accessible, community-based settings frequented by children and parents on a daily basis, and among the most



predictable and extensive providers of mental health services for children (Casat, Sobolewski, Gordon, & Rigsby, 1999), mental health researchers and policy makers urged that greater attention and resources be channeled into school-based services and collaborations between the mental health community providers and schools (Catron & Weiss, 1994; Casat et al., 1999; Leaf et al., 1996). The result was the implementation of various models of mental health services in schools (Kutash, Duchnowski, & Lynn, 2006). Two of the most influential models are the spectrum model elaborated by Mrazek and Haggerty (1994) and Weist et al. (2005), which conceptualize a spectrum of traditional mental health interventions implemented within school settings, and the Positive Behavioral Supports model, which uses educational and environmental redesign to enhance quality of life and minimize problem behavior (Stewart, Martella, Marchand-Martella, & Benner, 2005; Tincani, 2007; Tobin & Sugai, 2005). An assortment of and federal categorical funding, foundation grants, and local contributions are used to support these initiatives.

Conclusive research findings regarding the effectiveness of school-based mental health services have been compromised by the variability in models underpinning services and the diversity in person and environmental factors defining school systems. Despite these limitations, data over the last 20 years has pointed to favorable findings (Anglin, Naylor, & Kaplin, 1996; Armbruster & Lichtman, 1999; Dryfoos, 1996; Kutash, Duchnowski, & Green, 1997; Nabors & Reynolds, 2000; Rones & Hoagwood, 2000), including improved access for users who have no other source of routine medical care or health insurance; reductions in special education referrals and placement; declines in disciplinary referrals and suspensions; reductions in grade retention; lower rates of substance abuse and dropout; increased utilization of on-site mental health services; improved emotional functioning; higher levels of satisfaction reported by students and parents; reduction in barriers to accessing services; and, among other positive outcomes, a potential for cost savings compared to traditional care in clinics. Particularly noteworthy are findings from studies demonstrating mental health promotion and prevention programs are significantly more effective when delivered in schools versus other sites (Durlak & Wells, 1997, 2011). In the current issue, Manion, Short, and Ferguson report on a recent program scan of current practices in Canadian schools (Manion, Short, & Ferguson, 2013).

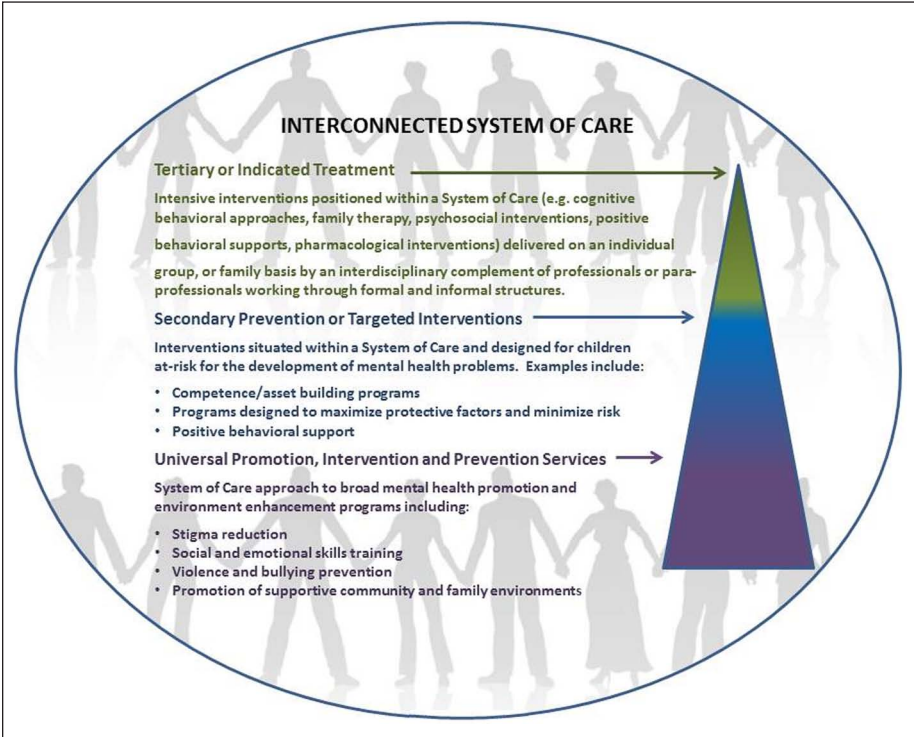
Within the context of positive findings, several limitations have also been observed including opposition from teachers and others who are not convinced that health and social services should be provided on school sites and a strong tendency to treat mental health services, in policy and practice, as desirable but not essential, which results in disjointed advocacy and planning and inevitable fragmentation in providing services and programs (Adelman, 1996; Adelman & Taylor, 1999; Adler & Gardner, 1994; Dryfoos, 1996). Moreover, community empowerment and involvement in decision making is notably absent and inadequate funding policies further contribute to intervention fragmentation (Adler & Taylor, 1999). Perhaps the most significant limitation relates to location of mental health services and supports within schools in the absence

of structural reform—a significant impediment to the full integration and coordination of mental health services. As a number of researchers have noted, in the absence of a joint governance structure wherein partners agree to pursue a shared vision, goals, principles, and values, the outside agency is not involved in school restructuring or school policy nor is the school system involved in the governance of the provider agency. Hence, issues of fragmentation, continuity of care, duplication of efforts, gaps in services, and a lack of regular and ongoing services, follow-up, and communication among key stakeholders generally endure.

Unlike full service schools, systems of care represent more than a network of services but rather a philosophy about the way in which services should be delivered to children and families, a philosophy built upon core values calling for service systems which are child-centered, family focused, community-based, and culturally competent. Additionally, the system of care concept goes beyond the concept of a “continuum of services” to include the mechanisms, structures, and processes needed to ensure that services are provided in a coordinated, cohesive manner such as interagency entities for system-level coordination, interagency case review processes, and provisions for case management. (Stroul, 1993)

## **Other Approaches and Models That Inform Children’s Mental Health Interconnected Systems**

Interconnected Systems is a relatively new and innovative systems of care model that is guided by a public health strategy and based on collaboration between systems. It is composed of a continuum of services that aims to balance efforts at mental health promotion, prevention, early detection and treatment, and intensive intervention, maintenance, and recovery programs (Barret, Eber, & Weist, 2012; Eber, Barrett, & Weist, 2010). In this model, resources from the school and community are pooled to produce integrated programs at the three levels of service need. The model consists of a series of interconnected ovals representing systems of universal (i.e., interventions that target the entire population to promote and enhance wellness by increasing pro-social behaviors, emotional wellbeing, skill development, and mental health), secondary (i.e., interventions that occur early after the onset of an identified concern, as well as target individuals or subgroups whose risk of developing mental health concerns is higher than average), and tertiary care (i.e., interventions implemented through the use of a highly individualized, comprehensive, and developmental approach that uses a collaborative teaming process in the implementation of culturally aware interventions that reduce risk factors and increase the protective factors of students). Although the model has been developed for use largely within schools and only includes a system of care at the tertiary level, we believe that it can be strengthened by overlaying systems of care on all three levels (see Figure 1).



**Figure 1.** Interconnected system of care  
Adapted from: Barrett, Eber, & Weist (2012).

In other words, to fully address mental health promotion and wellness, as well as prevention and treatment, in a comprehensive (i.e., interconnected), intentional, and value- and principally-driven ways, the original conceptualization of interconnected systems should be modified to incorporate a systems of care across all three levels. We believe that by doing this, the model will be in a much stronger position to achieve the shared values and principles of a child- and family-driven system, one that maximizes opportunities for family and child involvement and self-determination in the planning and delivery of *all* services within a community-based network of services.

## Public Health Approaches

Waddell, McEwan, Shepherd, Offord, and Hua (2005) argue that given the degree of unmet need, it is unlikely that *investing in more specialized treatment services will significantly reduce the burden of suffering associated with children's mental disorders*. Rather, what is needed is a public health approach to children's mental health, one that addresses the mental health of *all* children and focuses on optimizing positive

mental health, as well as preventing and treating mental health problems. The approach helps to shape environments in ways that enhance and support good health by engaging partners from many sectors in a comprehensive and coordinated manner. It also recognizes that the entire process needs to be informed by science and communities and adapted to the unique needs of particular populations.

In addition to shaping environments to promote health and prevent health problems in a population, a public health approach also includes action steps that guide the choice of what environmental factors to shape. The crucial first step of a public health approach is to gather data that can drive a decision-making process that is well informed and based on the best evidence available. Data are needed about child mental health issues within a community or population and the determinants that affect them. Knowledge of mental health needs, assets, gaps, and goals drives decisions about which outcomes are most critical to focus on and, in turn, knowledge about determinants drives decisions about how to affect outcomes. Identifying what to measure and what to do with the data is vital because this information offers a key starting point for leaders and coalitions that are interested in moving communities forward in adopting a public health approach to children's mental health (Miles, Espiritu, Horen, Sebian, & Waetzig, 2010, pp. 12-13).

## **Protective Factors and Individual Resilience Approaches: Pathways to Positive Mental Health and Wellness**

To effectively support children's mental health promotion, prevention, and treatment, we must also understand the pathways to wellness, as well as to vulnerability. We know there are a multiplicity of risks that can predispose children to negative outcomes—for example, genetic and biological predispositions, psychological trauma, and environmental stress. Importantly, we also know that there are numerous protective factors that can buffer these risks and lead to good developmental outcomes or resilience. Knowing these pathways can give us an awareness of the self-righting tendencies that move children toward normal development under all but the most persistent adverse circumstances (Luthar, 2003; Luthar, Cicchetti, & Becker, 2000; Luthar, Cicchetti, & Donald, 2006; Masten, 2001; Masten & Obradovic, 2006; Waddell, 2007; Waddell et al., 2005; Werner, 2000). The implications for promotion of wellness and prevention and treatment of mental health challenges are significant—we must shift the balance from vulnerability to resilience either by decreasing exposure to risk factors and stressful life events or by increasing the number of available protective factors through holistic approaches, those that recognize that mental health promotion, prevention, and treatment must address conditions within the family, school, and community, as well as within the child. To do so requires a system of care, one that encompasses a diverse set of coordinated and interdependent formal and informal

services based both within and outside a child's family and situated within the community settings that form a child and family's environment.

## **Our Vision - Everybody's Children**

Our community, including numerous agencies and organization, higher education institutions, and community partners, have coalesced on the need to actively develop, rigorously evaluate, generate critical insights, and systematically disseminate and use promising evidence-based strategies within a "real world" context if we are to effect positive changes to the children's mental health system. Our commitment is embedded in the belief that protecting children's right to thrive and flourish rests on an enduring societal commitment to promoting and maintaining the mental health of *all* children and youth, their families, and their communities. We seek to optimize thriving in children, families, and communities by implementing *demonstration* and *research sites* based on successful examples of *public health* approaches in the area of children's mental health, a growing recognition of the positive impact of systems of care, and a keen awareness of how healthy family, school, and community environments optimize children's mental health and well-being through attending to those protective factors that promote positive outcomes. We believe the "time is right" to identify new approaches to children's mental health and wellness in Canada by making a meaningful commitment to supporting research and the generation and translation of new scientific evidence and analytic tools that have the potential to contribute to the promotion of positive mental health and wellness, prevention of mental health problems, and effective treatment of mental health disorders in children, youth, and their families.

Our vision is strongly anchored in research that recognizes the need for optimizing the mental health of all children, families, and community members; holistic approaches rooted in the concepts of risk resilience, and protective factors; a population focus; and systemic approaches that are value- and principle-driven, as shown in Figure 2.

We are heartened by the recent announcement of the Ministries of Children and Youth Services, Education, Health and Long-Term Care, and Training, Colleges and Universities, Government of Ontario, that implementation of a strategy to achieve improved access to high quality mental health and addictions services, strengthen worker capacity, create a responsive and integrated system, and build awareness and capacity about mental health issues within communities is underway (November 2012; *Plan for Transformation of the Community-based Child and Youth Mental Health System*). Our demonstration and research sites will be informed by these proposed changes and within the context of "real-world" experimentation seek to field test and rigorously evaluate them alongside other innovative mental health promotion, prevention, and treatment strategies to improve practice at the policy, systems, clinical practice, and community levels.

### *System of Care*

*Value-based organizational philosophy that focuses system change on building collaboration across child-serving sectors for the purpose of improving access to an expanded array of coordinated community-based services for children, youth and families unencumbered by multi-agency jurisdictional fragmentation.*

### *Core Values*

1. *Driven by the needs of the child and his/her family; that is, child-centered with the needs of the child and family dictating the types and mix of services provided.*
2. *Provision of services in an environment and manner that enhances the personal dignity of children and families, respects their wishes and individual goals, and maximizes opportunities for involvement and self-determination in the planning and delivery of services.*
3. *Embraces the philosophy of a community-based network of services.*

### *Principles*

- *Incorporates a public health framework which places emphasis on promoting and supporting optimal mental health and resilience, takes a population focus incorporating promotion, prevention, and treatment, and understands the determinants of health.*
- *Comprehensive array of integrated, interdisciplinary formal and informal services that address the child's physical, emotional, social, and educational needs and reflects the unique needs of the community.*
- *Case management and conceptualization to ensure services are delivered in a coordinated way and are effective and appropriate.*
- *Collaborative approaches in which all members of the community participate and are invested in positive outcomes.*
- *Promote and adhere to evidence-based practice and documented outcomes*
- *Quality assessment and improvement activities continually guide and provide feedback to the program.*
- *Services are culturally and linguistically competent and reflect the cultural, racial, ethnic, and linguistic differences of the communities they serve.*
- *Investment in technology that facilitates collaboration and tracking child and family outcomes.*

**Figure 2.** Articulation of system of care within public health and resiliency frameworks  
Adapted from: Stroul & Friedman (1986) and Stroul & Friedman (2011).

## **Achieving Our Vision**

We will build two demonstration and research sites in community schools located in neighborhoods defined by the presence of significant risk factors associated with mental health challenges in children (e.g., poverty, minoritized). One demonstration and research site will be located in a secondary school and the other in an elementary school. In addition to the investment provided by the local school boards, considerable support has been garnered from community agencies, charitable organizations, corporations, and our local university for this initiative. Secondary and elementary schools were chosen given research findings strongly suggesting distinct developmental trajectories and programmatic needs for specific categories of mental health disorders in children and youth.

## **Why Locate in Schools?**

Although any one of a number of complexes could be considered as a location for mental health promotion, prevention, and treatment for children and families within their communities, sound research informs us that schools are the location of choice for these initiatives. Schools are second only to families in shaping children's development. They offer access to children as a point of engagement for addressing educational, emotional, and behavioral needs (Paternite, 2010) and are a natural entry point for the delivery of mental health services (Mennuti & Christner, 2010). Moreover, numerous research studies have demonstrated that schools are indeed the major providers of mental health services for children and youth (Rones & Hoagwood, 2000) and are overwhelmingly preferred by families seeking mental health services for their child 96% of families offered school-based mental health services initiated treatment while only 13% of families offered services in other community settings followed through with the referral (Prodente, Sander, Hathaway, Sloane, & Weist, 2002). Particularly noteworthy is a meta-analysis conducted by Durlak & Wells, 1997 of various school-based prevention programs. Findings indicated that school-based programs were more effective when delivered in schools versus other sites. In addition, as our mental health system continues to rapidly change, there is increased need to develop cost-effective treatments and methods for delivering services. School-located integrated services appear to constitute such advancement. There is considerable evidence to suggest that these services will prove to be a good value for families, children, health care providers, schools, and the community.

## **Why Demonstration and Research Sites?**

Our demonstration and research sites will be committed to improving the promotion of mental health and the prevention and treatment of mental health challenges in children at risk or presenting with mental health disorders through research, knowledge dissemination and transfer, and advocacy. A central purpose of our demonstration and



research sites is to pursue the objective of developing strength-based community-based mental promotion, prevention, and intervention services for children and youth within public health and frameworks and serve as a model for other national and international initiatives. We aim to test and demonstrate alternatives to traditional models of mental health delivery for children and youth. These objectives will be accomplished through research, education, and advocacy.

## *Research*

Through our association with our local university, we have unmatched opportunities to establish collaborative research enterprises between university-based researchers, mental health care providers, and members of the community. These collaborations offer the capacity to engage in research examining outcomes of health promotion, prevention, and treatment as indices of accountability. Using Hoagwood et al.'s (1996) model, studies will address diverse issues including clinical efficacy for children with specific disorders and those with heterogeneous symptoms; service effectiveness; field-based effectiveness to address issues of clinical impact; subjective experiences of the consumer (e.g., satisfaction with care, impact on the family); changes in environments that occur as a function of interventions targeted toward the child or his/her primary environments (e.g., marital and family functioning, level or intensity of family stressors and disruptions); level, type, duration, and change in service utilization or availability; assessments of relationships between or among service organizations; assessments of financial structures and funding streams, as well as costs of specific services; and examinations of the circumstances, contingencies, and actions that support and impede systems change, among others.

## *Education*

A principal role of our demonstration and research sites is to bridge the gap between theory, research, and practice for mental health professionals. There is a menu of promising systems, policy, procedural, and intervention practices to support children's mental health; however, many educational, health, and social services professionals and paraprofessionals lack the training to implement specific practices and thus, tend to be more influenced by clinical judgment than by research when designing, implementing, and evaluating certain practices. We seek to move research into action by developing the knowledge, skills, and competencies necessary to implement practices with fidelity. The ties of our research and demonstration sites to our university and community are an important one. Multidisciplinary educators and researchers from education, social sciences, medicine, and nursing, among others, will play a significant role through the provision of professional education, development of research and analytical methods for effectiveness assessment, and the dissemination and translation of knowledge. The practical wisdom of our community partners will ensure that the questions that are asked are indeed those that are relevant and transformative.

Parents facilitate the interaction between the child and the service system, and as such, represent the “central dimension” of the systems of care (Tannenbaum, 2001). Empowering families through education is recognized as a best practice in achieving quality services in child and youth mental health. Empowered families have the knowledge, skills, and resources to enable them to gain positive control of their own lives, as well as improve the quality of their life styles and those of their children (Singh, 1995, p. 13). We believe that the full participation of family members in planning, implementing, and evaluating services for their children with mental health needs is an essential aspect of providing mental health services to children and families; indeed, family members must be seen as essential partners, both at the individual child and family level and as key participants in system-level planning and evaluation (Friesen & Pullman, 2002). We seek to empower and engage families through providing education that will empower them to actively participate in case planning and treatment, as service users and providers, in decision making within service delivery, through involvement in service evaluation, monitoring, and planning, and in policy decision making (Chovil, 2009).

### **Advocacy**

We believe that effective community advocacy is needed to convince among other things, fundamental systemic and structural reform is necessary to ensure that all children have access to appropriate services within primary developmental settings. Further, advocacy efforts must be directed toward radical change and altering financing mechanisms to strategically support the infrastructure and services comprising the children’s mental health system. Our energies will also be expended to advocating for an outcome-oriented approach, one that ensures ongoing evaluation and comparison of differing methods and strategies, the assessment of research translation strategies to determine their effectiveness in positively changing outcomes in clinical practice, behavior, and outcomes; and, research findings are an integral element of all decision making. As our initiative strengthens, we aim to develop long- and short-term advocacy objectives that take into account our audiences and potential influencers, key messages, and talking points. We will solicit the support of effective spokespeople, decision makers, and partners in our efforts to help enact policy changes that will ensure positive mental health outcomes for all our children.

### **Conclusion**

These are exciting and promising times in Canada for realizing systemic changes to the children’s mental health system. Increasingly, we have seen policy makers “step up to the plate” to reform the child and youth mental health systems. Success in implementing sustainable and effective change; however, is highly dependent on continued exploration and innovation, reflective practice, and research on policy, implementation, and program development within “real-world” contexts. Together with policy makers, mental health care providers, and our community, our research and demonstration sites

hold considerable promise for evaluating outcomes stemming from these proposals, as well as identifying novel ideas and projects and supporting high impact practices that will further lead to innovative solutions in the children's mental health system.

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