THE BEST WE HAVE TO OFFER

New Brunswick Child & Youth Advocate

Défenseur des enfants et des jeunes du Nouveau-Brunswick

Child and Youth Advocate (Office)

The Child and Youth Advocate has a mandate to:

- ensure that the rights and interests of children and youth are protected;
- ensure that the views of children and youth are heard and considered in appropriate forums where those views might not otherwise be advanced;
- ensure that children and youth have access to services and that complaints that children and youth might have about those services receive appropriate attention;
- provide information and advice to the government, government agencies and communities about the availability, effectiveness, responsiveness, and relevance of services to children and youth; and
- act as an advocate for the rights and interests of children and youth generally.

New Brunswick Child&Youth Advocate

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MESSAGE FROM THE NB CHILD AND YOUTH ADVOCATE

As the New Brunswick Child, Youth and Seniors' Advocate, my perspective is that the Province has an obligation to ensure that every child or youth receive the very best service we can offer to meet their mental health needs.

Sparked by the tragic loss of 16-year-old Lexi Daken, the Minister of Health, Dorothy Shephard, asked our Office to review all youth mental health services offered in the province.

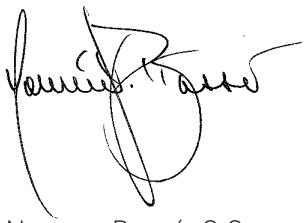
As we embarked upon this exhaustive independent review, I felt fortified by the unprecedented response from the public, youth and professionals who were willing to share their experiences and expertise in the search for solutions.

More than 4000 respondents filled out our community online survey. Over 250 participants took part in our 10 different public consultations across the province. Canadian and Global Experts in the field of Youth Mental Health and Suicide Prevention, Professional Organisations and Youth Community Agencies contributed. And dozens of in-person interviews were conducted and analyzed to complete this report.

I would be remiss if I did not thank publicly all the members of the Advisory Council, and its two co-chairs, Graydon Nicholas and Léo-Paul Pinet. All my gratitude is also due to the Youth Advisory Committee and its two co-chairs, Stacie Smith and Sue Duguay. The invaluable input and immense effort of the First Nations Advisory Council has been greatly appreciated. The Deputy Advocate and Senior Legal Counsel, Christian Whalen, who led the review team, deserves special recognition, as does the dedication and integrity of the Child and Youth Advocate Staff who contributed countless hours for the completion of this report.

This generous outpouring of help resulted in 12 recommendations, 10 interim recommendations, and an independent report from our First Nations Advisory Council, submitted to government as an opportunity for substantial change for Suicide Prevention and Youth Mental Health Services in New Brunswick.

I expect the public will ask government to be accountable and implement all the recommendations, as our team did not leave one stone unturned to identify the gaps and explore solutions to best serve our striving children and youth. We owe them The Best We Have to Offer to prevent youth suicide and ensure we can open doors to a brighter future.



Norman Bossé, Q.C.
NB Child, Youth and Seniors' Advocate

This Report is dedicated to the memory of Lexi Daken.

Media Advisory

As a common effort to prevent suicide, the Child and Youth Advocate encourages media to follow the Guidelines for Suicide Media Coverage provided by The Canadian Psychiatric Association (CPA) 2017 Policy Paper, as well as the recommendations of The World Health Organization (WHO) for the responsible reporting of suicide.

Recommendations include using appropriate language, trying to reduce the stigma around mental disorders, and providing information about alternatives to suicide. Pertinent resources for people contemplating suicide, such as crisis services, should also be provided and can be directly linked to reports that appear online. Simplistic or glorified depictions of suicide should be avoided, and suicide should not be presented as a way of solving problems. Reports should avoid details of suicide methods, particularly if they are novel or unusual. Recommendations also include that, where possible, suicide should be covered by or with the input of health reporters who are best positioned to contextualize suicide within the broader topic of mental health.

- Media Guidelines for Reporting on Suicide: 2017 Update of the Canadian Psychiatric Association Policy Paper : https://www.cpa-apc.org/wp-content/uploads/Media-Guidelines-Suicide-Reporting-EN-2018.pdf
- Recommendations for the responsible reporting of suicide, World Health Organization (WHO): https://www.who.int/mental_health/prevention/suicide/resource_media.pdf

Get Support:

- **Kids Help Phone :** https://kidshelpphone.ca
- **Chimo Helpline (New Brunswick) :** http://www.chimohelpline.ca | 1-800-667-5005
- **Tel Jeunes :** https://www.teljeunes.com/Home
- **211 NB (New Brunswick) :** https://www2.gnb.ca/content/gnb/en/departments/social_development/news/news_release.2020.10.0532.html | 211
- **Bridge the gap :** "https://nb.bridgethegapp.ca/

Find more resources : **https://programmelemaillon.com/en/home/welcome**

FOR I AM LEAVING

Silver sunlight.
As Mother Earth
begins to weep.
For the possible loss
of yet another child,
Has immensely
cut deep.
4 unstable breaths.
The wind howls and moans.
“Help her”,
She pleads.
For I am bleeding.
“Where I am going is unknown.”
Please take care of her.
For she cannot breathe.
With the essence
Of her pain,
She has suffered in vain.
It has been proclaimed,
That she simply
cannot stay sane.
Or so they claim.
It has formed a dagger
In which has made
her conscious stagger.
Piercing her mind body and soul.
Wrapped in water,
She watches her daughter
drift away.
Barely breathing
Yet she is pleading
“Please watch over my baby”
For I am leaving.
-A.J.N.

“Poem submitted by an indigenous youth in the Advocate’s Alternative Forms of Expression category in the Review website’s call for submissions”

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EXECUTIVE SUMMARY

The Child, Youth and Senior Advocate has completed a Review of Youth Suicide Prevention and Mental Health Services in the Province of New Brunswick following the death of Lexi Daken at the Dr. Everett Chalmers Hospital in Fredericton on February 24th, 2021. The Advocate gave public notice of this review at a press conference on March 5th, 2021. With funding from the Department of Health, a large staff team was assigned internally from the Advocate's Office and augmented with external consultants and research program staff. A consultation document and website for the review were launched in early May and an Interim report with 10 recommendations filed with government on June 15th.

The Final report and recommendations are informed by review of the extensive documentary disclosure by government, augmented by internal literature review and research, as well as extensive public consultation, via over 4000 online survey responses, over 10 community online consultations, key informant interviews, expert dialogue sessions, individual citizen feedback and formal submissions. The Advocate's findings are summarized in two parts of the report relating firstly to the individual case study of the facts surrounding Lexi Daken's death and secondly from the findings in relation to the broader review questions framed in the Advocate's Consultation document.

The final report finds that acute care youth mental health settings lack appropriate mental health training and adequately resourced specialized services, both in terms of physical infrastructure and human resources. They also lack standardized suicide risk assessment tools and practices to adequately triage mental health cases that present at emergency rooms. The Review found that youth mental health and suicide prevention services in the Province were suffering from a chronic shortage of psychologists and psychiatrists, as well as from a lack of coordination between formal systems of care and community-based programs such as Integrated Service Delivery (ISD).

In relation to the broader systemic issues raised by the review, the Advocate found that New Brunswick youth mental health services remain far too reliant upon crisis care, with rates of youth hospitalization for mental health that are 40% higher than the national average. More effective services (assessment and intervention) could be possible if the Province invested earlier and more significantly in community-based care in preventative and early care settings. The report inventories a number of promising community-based services and informal system supports that deserve more sustained investment and assistance.

The Review also found that many shortfalls in the current system could have been addressed if better governance and accountability mechanisms had been in place to track and implement earlier recommendations. The report also puts forward an Accountability Framework for health proposed by the UN Committee on the Rights of the Child, in application of Article 24 of the *Convention on the Rights of the Child* which proclaims the child's right to enjoy the highest attainable standard of health and which insists upon mechanisms to hold government accountable for the delivery of Available, Accessible, Acceptable and Quality health services (AAAQ).

Using this Framework, the Advocate proposes dozens of improvements in services to government grouped around twelve broad recommendations. The Report's recommendations begin with a call for a Minister for Children and Youth, supported by a small central Secretariat and an interdepartmental committee for children and youth, as recommended in 2008 in the Advocate's *Connecting the Dots* report. This primary recommendation would create a centre of responsibility within government for ISD and for child and youth rights, and coordination of services to children in general - similar to the agencies in government that exist for women, disabled persons, official languages, la Francophonie and Aboriginal Affairs.

A second lead recommendation calls for a Provincial Action Plan for child and youth mental health and suicide prevention aimed at reinvesting in community-based care and services that are earlier, more preventative and responsive solutions than hospital-based crisis care.

These are followed by a recommendation for a principled commitment to reform founded upon child rights-based analysis and approaches including domestic incorporation of the Convention on the Rights of the Child into domestic law. Following this recommendation is an equally foundational recommendation to continue the process of review while responding to early recommendations for reform stemming from First Nations Communities themselves who bear a disproportionate burden of mental health and youth suicide as a result of the intergenerational and historic impacts of colonial policies.

A fifth recommendation deals with the much-needed improvements and reform of Integrated Services Delivery (ISD) as a central mechanism for improved community-based care. The Advocate is calling for a new training framework to support ISD clinical standards along with trauma informed care and child rights-based approaches. In this recommendation, the Advocate also calls for a new ISD human resource plan to address shortfalls in staff complements including critically lacking psychologist appointments as well as the need for more social workers, counselors and behaviour intervention workers in schools and community settings.

The report also calls for the establishment of a Provincial Child and Youth Health Rights Advisory Council mandated to reinforce child and youth participation principles and practice in policy development and service monitoring, at all levels of administration and service delivery.

These leading thematic recommendations are followed by four recommendations addressing the system improvements that can be achieved through the application of the AAAQ framework. The Advocate recommends improved *Availability* of youth mental health and suicide prevention services by developing a child and youth mental health resource plan to meet clinical needs over the long term and the hire of professional recruiters to put the plan into effect; the establishment of provincial benchmarks to eliminate wait-times for access to mental health care; and the extension of mobile mental health crisis units to 24/7 availability.

The Advocate also frames recommendations for improved *Accessibility* of services by: improving investment in navigation supports such as the Link Program, 211 and 811 services and linking these up with ISD and community-based service centres; expanding free counselling services using the Atlantic Wellness model; expanding employee benefits to routinely ensure and provide access to more psychotherapy or counselling sessions; piloting the phased expansion of Medicare to cover mental health psychotherapy or counselling services for children and youth under 30, and expanding the hours of emergency room psychiatric nurse availability and social worker supports.

All of these accessibility improvements should come while ensuring access to culturally safe care in both official languages and adapted services for vulnerable populations and specialized diagnostic groups and their carers.

The report includes recommendations for improved *Acceptability* of services by: insisting upon the provision of specialized child and youth psychiatric care in appropriate pediatric settings across all regional hospitals; insisting upon the use of validated mental health triage assessment tools, formal and validated suicide risk assessment and interventions, strict enforcement of policies preventing the use of "no suicide, no self-harm" contracts to safety, constant professional training and upgrading in youth suicidality, cultural safety, empathic care and quality assurance controls; creation of revised community health standards for child and youth mental health adapted to the urgency of timely intervention for this population reduced from a maximum wait-time of 10 business days to 3 to 5 business days and aiming for an immediate connection to care; and institution of a process of ongoing service reviews to ensure acceptability of care for all vulnerable populations and diagnostic groups.

The fourth criterion of the AAAQ framework, *Quality Care*, leads to additional recommendations to ensure: child and youth mental health service updates are imbedded in all quality assurance mechanisms in hospital-based care and community-based care, including ISD, and that all teams are consulted in system improvement affecting their service delivery; improved training for compassionate and youth-centred care across all service settings; better use of trained social work professionals in all care settings to assist with emergency care, discharge planning and post-discharge care; school curriculum reforms to insist upon mandatory personal wellness classes in all grade levels, improved mental health fitness training to equip all youth to be the peer supports they want to be, to improve youth resiliency factors across all grade levels through both curricular and extra-curricular supports; and improved training in education, nursing, medicine, law, policing and social work programs to insist upon trauma-informed care, child rights based approaches, suicide ASIST training and social and emotional learning.

Finally, the Advocate Report closes with two recommendations related to: i) prevention and public education measures including a call for a separate study into the Quality of Family Life in New Brunswick and the adoption of a Provincial Youth Suicide Prevention Strategy; and ii) improved data collection and research as supports to quality assurance and continuous improvement.

The title of the report "The Best We Have to Offer" is a nod to the 1924 *Declaration on the Rights of the Child*, the first international legal instrument to recognize children as rights holders. Its preamble adopted by the League of Nations shortly after the end of the First World War closed with a reminder that all members of the human family have special obligations to children, stemming from a central obligation to offer children the best of ourselves and the best life we possibly can. It is in this spirit that these recommendations for reform of youth suicide prevention and mental health services are offered.

"TO KNOW HER WAS TO LOVE HER"

So many of us know someone like Lexi Daken and that is why the news of her death shattered us all. Our own 'Lexi' touches our lives in a myriad of ways. She is the bright light who adds that much needed sunshine to everyday life. We cannot imagine a life without Lexi and so when we learn that someone so special found life too painful to continue, we ask, "How could this have happened?" For if it happened to Lexi Daken, then what about our own Lexi we hold so dear?

Lexi is your brilliant student. The one who is always on task, giving it her best effort to produce quality work, or keen to lend a hand wherever needed. She is the kid who is kind to everyone. The kid in the class photo with the brightest smile.

Lexi is your star athlete. The kid on your team with that winning combination of natural talent and sportsmanship, always quick to offer words of encouragement to a teammate when they are needed most. She is a perfectionist.

Lexi is your best friend. She is everyone's friend because she reaches out to those who need a little compassion. She is the one you can always depend on because she cares about you. The one with the bizarre sense of humour masked by a seemingly innocent façade. The friend you can talk to about anything at any time.

Lexi is your niece or your granddaughter. The one who loves coming for visits, listening to your stories and baking up a storm.

Lexi is your big sister whom you adore even though she drives you crazy. The one who always makes time for you, from creating a home spa day, to playing video games, to wrestling on the living room floor. She is the one you always look up to and the one who would fiercely stand up for you in any situation.

Lexi is your little sister and your best friend. She is the one you tell everything to and vice versa. She is the one you can joke with and laugh with until you cry.

Lexi is your daughter. She is the precious newborn you brought home from the hospital who one day seemed to transform before your eyes into a tall and beautiful young lady. She is the one who adores spending time with you, chatting your ear off on long drives, or getting her hands dirty on a hunting and fishing adventure. She is the one who never stops making you proud. The one you would do anything for.

Lexi is the girl who people admire. She is outgoing, witty, hilarious and kind. She is also a spitfire with a contagious laugh that fills the room. Lexi brightens your life.

But Lexi Daken was plagued by a darkness inside.

A darkness that obscured all the light in her life, overwhelming her and leaving a shadow behind for all she loved.

Everyone has a Lexi in their lives, but Lexi did not live to have everything in her life. She was the girl with endless potential that was never realized.

She will never graduate from high school.

She will never go to prom.

She will never fulfil her aspirations of becoming a neurologist.

She will never experience the pride of buying her first home.

She will never go on another summer vacation.

She will never be a mother.

She will never grow old with the one she loves.

Lexi will never be replaced.

Lexi Daken began preparations to end her life three and a half months before she died, with thoughts of suicide filling her mind every hour. The anguish of past life experiences and body image insecurities combined with feelings of rejection and abandonment were amplified by severe depression.

When the pain Lexi felt became unbearable and to the extent that she could not trust herself to remain safe from self-harm, Lexi went to the emergency room accompanied by her high school guidance counsellor. She required urgent care. Lexi's only shortcoming was that her ailment wasn't physical in nature. She wasn't hemorrhaging, but she was still crashing and in desperate need of a different kind of life-support. She did not receive the hospital admission or other treatment she and her allies were seeking, or a convincing reason as to why not. The health services received felt to her, her family and friends like little more than a "band-aid solution". Although that might not be quite accurate, for band-aids at least stop the bleeding and offer a sense of relief and comfort, much like when a mother "kisses it better." Lexi's emergency room experience may have made the hurt worse.

Lexi's main goal that day in going to the hospital was to get help. Her condition had deteriorated to beyond what her guidance counsellor felt comfortable managing on her own. She had exhausted all the strategies she knew of; Lexi required more critical care at this point.

At the end of a full day hoping for a psychiatric assessment, Lexi was seen by a physician who made note of all of her concerns and seemingly left it up to Lexi's discretion whether or not the on-call psychiatrist should be consulted. Specifically, the physician indicated to Lexi that if she couldn't promise to keep herself safe at home, the on-call psychiatrist would have to be called in. Lexi could not make this promise the first time the physician asked and so "Will not contract to safety" was noted in her chart. When she was seen again by this same medical professional 1 1/2 hours later, when her bloodwork results were available, the physician again asked if she could keep herself safe. It was around 9pm at this point and Lexi was exhausted from waiting all day. She hesitated, but eventually agreed that she wouldn't hurt herself at home. The physician recorded in Lexi's chart that she contracted to safety at 21:01. Lexi was then discharged with the number for the Mobile Crisis Unit and an urgent outpatient referral for psychiatry.

Lexi was left in the hands of a system that was meant to help her but was unable to connect her with the compassionate care she needed. A system where it has become acceptable and standard practice to send a suicidal youth home because she agreed to keep herself safe, even without having had a suicide risk assessment performed. Perhaps Lexi agreed because she always did what others wanted her to. She never wanted to be a burden. She never wanted to impose or disappoint.

It would appear that many young people and their families, as well as youth services and educational professionals, have doubts about the ability of emergency rooms to make the necessary connections to psychiatry supports in moments of crisis. But can we fault the hospital for lacking this level of quality emergency psychiatric care? Does the frenetic pace of an emergency room offer the most ideal and appropriate setting to treat suicidal patients or others in urgent mental and emotional distress?

After her first overdose attempt in November 2020, Lexi was connected with an Integrated Services Delivery (ISD) child and youth team in her area. After the completion of her therapy sessions with a private therapist, Lexi was to switch over to receiving services with an ISD clinician, however, she never had the occasion to meet with this person. Many factors contributed to this, most notably the ISD clinician's full schedule already occupied with other youth, and the COVID-19 schedule of alternating in-class attendance. But perhaps the principal reason Lexi did not find help in ISD was due to a systemic failure in that the ISD Fidelity and Practice standards developed in 2017 have yet to be implemented four years later. ISD Child and Youth teams lack operational guidelines and continue to apply mental health and addiction guidelines that were developed prior to ISD's provincial implementation. It is impractical to expect a system as intricate as ISD to function optimally for every client when there are no effective standards to guide its service delivery.

Lexi was someone who endlessly gave of herself to others in need, but when the time came where she was the one who needed help, she was failed by a system with little room for compassionate care. A system lacking formal guidance for those working with our most vulnerable youth. This failure affected Lexi deeply as she realized that she was not given the time and attention that would have been second nature for her to give others.

The reasons that people die by suicide are complex and require a multifaceted prevention strategy, hopefully Lexi's tragic death will lead to the development and implementation of much improved and better resourced mental health services in New Brunswick.

INTRODUCTION

"The secret message communicated to most young people today by the society around them is that they are not needed, that the society will run itself quite nicely until they — at some distant point in the future — will take over the reigns. Yet the fact is that the society is not running itself nicely... because the rest of us need all the energy, brains, imagination and talent that young people can bring to bear down on our difficulties. For society to attempt to solve its desperate problems without the full participation of even very young people is imbecile."

Alvin Toffler

"This move from a system-centred, pathology-oriented, medical/psychiatric model to a client-centred paradigm is the secret to transforming our system in Canada. To get started, it merely requires a change in perspective. We must get out of our egocentric tendencies and work hard to understand the unique, diverse and essential subjective experience of the client. We need to start understanding that empathy and client-centredness are not only clinical concepts, but are vital tools for administrators and leaders if we hope to ever make real change in our systems. What if the client were your daughter?"

Todd Leader, It's Not About Us

"Youth even in its sorrows always has a brilliancy of its own."

Victor Hugo

Hillary, Jordan, Gabe, Samuel, Emily, Mona, Ashley, Lexi.

These are only some of the names of young people whose loved ones we have met through this Review whose lives were cut short by suicide. The grief of this loss never truly heals. We have heard also from people who have attempted suicide and have healed and moved on, young people with recent experiences and old people who have carried the trauma of their childhoods with them for many years only to find peace late in life. We have heard from many more families worn down by the mental anguish brought on by having to help their child through their own journeys with mental illness. And we have heard from youth who are wanting to connect with care, wanting to have someone to talk things through with, youth who are tired of waiting for help and youth who are concerned about the cost of mental health for them and their families.

Youth and their families have taken part in this Review in overwhelming numbers. The thirst in New Brunswick for this conversation is troubling in itself. Mental illness affects so very many of us, touching on one in five Canadians, and proportionally even more New Brunswickers[1], and it affects us very deeply. Whether we are grappling with it ourselves or supporting loved ones who are going through it, the impact of poor mental health can knock us off our feet. It affects job or school functioning, it impacts our relationships, our ability to be there for others, including friends and family. It affects us more than almost anything else. Why then, we ask, is it so poorly resourced and addressed? If we have to prioritize spending in a context of scarcity of resources, could we not at least offer children and young people the supports they need to improve their mental health?

In the following report we will take a long hard look at everything that has been done to address the problems of youth suicide and youth mental health services delivery in New Brunswick over the past twenty years and we will bring forward recommendations – some old ones and many new ones – for systemic change in the hope of improving outcomes for today's children and youth as well as succeeding generations. We will alternate our lens from the up-close personal experience of one family's journey, Lexi Daken's, leading to her tragic end, to the broader systemic approach that has informed our overall review.

As with our Interim report and recommendations we will begin with a word about our methodology but we will then turn to a summary of our findings. These will be grouped in two parts. The first set of findings will touch on emergency room care and its intersection with family and with Integrated Service Delivery and school-based supports as experienced in Lexi's individual case. The second findings stem from our systemic review of provincial services in this sector across many departments and agencies including the Horizon Health and Vitalité regional health authorities and the Departments of Health, Social Development, Justice and Public Safety, Education and Early Childhood Development and Post-Secondary Education and Labour. We will summarize here as well what we have heard from individual youth and their families across the province and from youth organizations, community-based service organizations, the philanthropic sector and professional associations as well as from individual professionals, researchers and other experts. These findings will be grouped by theme in relation to the history of youth mental health services in New Brunswick, clinical findings and data in relation to youth mental health and youth suicide, the human rights and legal framework for such services, the health equity challenges in this field including equal access to the right to health and right to life for Indigenous children and youth in New Brunswick and finally the challenges experienced by youth and their families across various public health service sectors and the current and prospective role of communities, the not-for profit sector, philanthropy and government.

Following these findings, we will be able to outline the final recommendations to government stemming from this review. These recommendations are informed by our child rights-based approach and flow from the obligations the Province has towards children as rights holders and how we as a society can most effectively implement the right to health and the right to life for children and young people and how these principles should inform our approach to youth mental health services. The first grouping of recommendations flow from the broad orientations stemming from our review findings and which were identified already in our interim report *A Matter of Life and Death*. These are: i) a new governance model for integrated youth mental health services; ii) an improved emphasis on accessible, quality community-based care; iii) a rights-based approach to service transformation; iv) equal access to health for all and particularly for Indigenous children and youth; v) a commitment to quality improvement particularly in relation to Integrated Service Delivery; and vi) a strengthened commitment to child and youth participation. A second grouping of recommendations will be outlined in relation to the key criterion of the child's right to health in relation to availability, accessibility, acceptability and quality of services. Finally, the third grouping of recommendations will touch on matters not covered elsewhere but flowing generally from a commitment to: i) improved emphasis on Prevention and Public Education, including the development of a provincial youth suicide prevention strategy and further study into the quality of family life and the impacts of toxic stress on children and young people; and ii) strengthened investment in continuous improvement and research as well as quality assurance, data collection and monitoring.

Further to these recommendations the report will set out in several appendices, background reports that were prepared for this review and which allow us to treat in greater depth certain key topics which we were only able to touch upon in the final report owing to limitations of space and time, but which we felt would benefit from broader public discussion and debate. In the appendices there is therefore a deeper treatment of issues related to Indigenous child and youth mental health, the impacts of the COVID-19 pandemic on child and youth mental health services, the need for a separate youth suicide prevention strategy for New Brunswick, and also the need for a child and youth specific youth mental health services professional recruitment and retention strategy.

METHODOLOGY

Shortly following Lexi Daken's passing the call went up for a commission of inquiry into her death and into youth mental health services. Our goal was to get ahead of that demand, as a Provincial Advocate for children and youth and demonstrate the capacity of an independent Legislative Office to carry out the required analysis and review in a timely and effective manner. All of our work this spring would not have been possible without two things: a) the additional funding secured through the Department of Health to hire external consultants to assist with the review and backfill permanent staff positions assigned to it; and b) the broad and varied participation in every stage of the review by New Brunswickers themselves. Because of these circumstances we are confident, as we complete this review, that we have been able to produce in a very compressed time period a thorough review of this matter. The advantages of having an independent Legislative Officer carry out this task are in our view considerable and our understanding of these advantages have been confirmed through the review.

As a specialized ombudsman for children and young people, the Advocate has significant experience in listening to young people and putting their voices forward in joint decision-making. The Advocate has expert knowledge of child and youth rights and of the legal obligations the Province has towards young people. The Advocate, having been established 15 years ago in 2006, has the expert knowledge of government services over time, how services have evolved, what was done in the past and why changes were brought in. Unlike hired experts from further afield, the Advocate knows the local terrain, what will and what won't work. As an independent Legislative Officer, the Advocate has significant experience in influencing law reform and change. The Advocate knows the machinery of government and has the trust and confidence of government and of all members of the Legislative Assembly to carry out expert reviews impartially and thoroughly. The Advocate has all the powers of a Commissioner of Inquiry but acts as a specialized ombudsman for children and other vulnerable populations, preferring informal fact-finding methods to cumbersome, formal or adversarial ones. The Advocate brings the lamp of scrutiny to dark places of maladministration, allowing swift corrective action to take place so that justice, fairness and equal access to services are restored.

Because of these attributes of our statutory mandate and because of the funding and broad participation of New Brunswickers referenced above we are confident that the road-map outlined in the report below offers a credible and attainable path to transform service delivery and improve youth mental services and to reduce the risk of youth suicide in beneficial ways. We know that New Brunswickers want this change, that it is urgently needed, and people do not want to wait for it any longer.

The Review began on March 5th, 2021. Pursuant to section 19 of the *Child, Youth and Senior Advocate Act*, notices of investigation and review were sent to the Departments of Health, Education and Early Childhood Development, Social Development, Justice and Public Safety and Post-secondary Education, Training and Labour, as well as to the Horizon and Vitalité health authorities. In response to these notices, public agencies and ministries assembled over 500 records of material that were disclosed to the Advocate's Office. A team of ten members of the Advocate's permanent staff was assigned to work on the Review. Additionally, three Bachelor of Social Work Students from St-Thomas University, three students from the UNB law faculty, two professional

consultants from the First Nations Health services field and two retired Assistant Deputy Ministers for Addictions and Mental Health Services were hired to support the Review. This review team was supported by an Advisory Board made up of just over sixty members including: a stakeholder Advisory Council representing research, community sector and government stakeholders; a Youth Advisory Council including a diversity of youth views from across New Brunswick of youth with lived experience of mental health services and their peers; as well as a First Nations Advisory Council representing youth, elders, health directors, professionals and community and public sector allies involved in Indigenous youth mental health services.

Our methodology included our case study of the events leading to Lexi Daken's death as well as a broader systemic review of youth suicide prevention and mental health services. For the case study, Wendy Cartwright, our coordinator of systemic investigations, was assigned to the Lexi Daken review. Separate file disclosure was sought in relation to these issues and the investigation into the services to Lexi through ISD, and at the Dr. Everett Chalmers Hospital (DECH) during her visits in November and February was subject to its own investigation plan. Fourteen interviews were carried out with key witnesses to the events leading to Lexi's death. The review of records and key informant interviews allowed the investigator to make a number of preliminary findings and recommendations which were then incorporated into the broader list of recommendations and informed the final report.

The broader systemic review was informed by an environmental scan, literature review and statistical analysis as well as by the qualitative feedback gathered by listening to New Brunswickers via our online portal, the Advocate's virtual consultation and listening tour, a survey of youth and adult New Brunswickers, key informant interviews and formal submissions from community stakeholders, researchers and professional associations. In total we heard from nearly 5000 New Brunswickers through the course of the Review. We also heard from leading experts nationally and globally in the field of youth suicide prevention and mental health services and identified existing best practices through our environmental scan and literature review. The internal review team developed a research plan and project charter early in the process which allowed all of the feedback received and research product to be captured in a series of thematic briefing notes. This final report, recommendations and appendices are the distillation of this research and feedback, as revised and enhanced by the project Advisory Board.

A note about suicidality, confidentiality and privacy rights

Dealing with suicide, especially the death by suicide of a young person, is never easy. For parents and families it presents a grief that may not ever fully heal. For classmates, educators and health sector or youth sector workers involved with the young person, as secondary victims of suicide, it can also have traumatic impacts that should be professionally addressed through early postvention. As we approached the task of writing this report, as advocates for children and youth, we also wanted to remain alert to the well-known risks that accompany youth suicide, including its contagion effect. We are concerned to note that following the reports of Lexi Daken's death, the number of youth referrals to mental health supports in the Dr. Everett Chalmers' Hospital region increased by almost 80% between January and March of 2021.

That is why we have added the notice to media to the front of this report to refer them to Canadian Psychiatric Association and World Health Organization guidelines on reporting of suicide. It is why we have provided contact information at the front and back of this report on who to contact if you or someone you know as a reader of this report is thinking about suicide. We want to minimize the risk of suicide and of youth suicide especially by every means possible, and yet we need to talk about it. We need as advocates to do our due diligence in reviewing in detail the aspects of Lexi's case, and delving deeply into this conversation with other New Brunswick families who have experienced youth suicide and which even today remains shrouded in stigma, silence and taboo.

The good news is that according to some of the experts we spoke with as many as 95% of people who have ever actually thought of suicide do not die as a result of it. Suicide, like cancer, can be beaten. But we may not share that news as much as we should. We don't want to talk about suicide for fear that we may give people more license, but the silence around suicide may exacerbate the feelings of hopelessness people may have. There needs to be more ways to help people cope with and overcome these feelings and find a path to recovery. Improved compassionate care addressing underlying traumas through therapy and healthy living is the path forward for most survivors of suicide, including its secondary victims.

It is extremely challenging to address the problem of youth suicide effectively because of its complexity. The etiology of suicide is multifactorial and includes biological, genetic, psychological, social and environmental factors in a complex interaction. Suicide risk assessments can and must be carried out, but they are not good at predicting future risk of suicide, but mainly the immediate risk at hand. The work of suicide prevention is therefore iterative and has to be operationalized repeatedly and expertly every time in order to be effective. In some youth, with certain diagnoses the risk may wane so much as to disappear completely, in other cases the risk may be chronic and remain present throughout their lives.

We may not be able to eradicate suicide completely, but we do know that every suicide is preventable. With more training, with more attention to risk assessment and safety planning and more timely offers of clinical supports, we know that we can materially reduce the rate of youth suicide in New Brunswick and in Canada. We look forward to a near future as Todd Leader has proposed, where the stories written are not about people complaining about a system that lacks compassion, leaves them feeling unheard, with long wait-times and negative client experiences, but are instead celebrating our successes in reducing youth suicidality and the onset of mental illness in youth. In order to get there however we have to be clear eyed about our current reality and able to talk about it openly and without stigma so that things can improve.

As we finalized the draft of this report and prepared for its release, some experts have suggested that we should remove some or all of the details of Lexi's case, that we should not point any fingers at staff who may become discouraged, that patient privacy requires more circumspection, that the report needs to build trust in the system, not deter anyone from seeking appropriate care, not trigger any victims or potential victims of suicide. We have welcomed all of the advice and feedback received. While the *Protection of Personal Health Information Act* does not apply to the Advocate as a Legislative Officer, we have found it instructive to review its provisions and in particular subsection 25(4) and paragraphs 26 (b) (c) and (d) of the Act which confirm that any privacy rights of a deceased person lies with their estate and that substitute decision-makers exercising authority under that Act should consider the wishes, values and beliefs of the deceased, the benefits versus the negative

consequences of disclosure and whether the intended purpose of the collection, use or disclosure of information can be achieved otherwise. These are the same general considerations which guide the Advocate in the exercise of his authority to publish a report or to make certain information known in support of his recommendations, a decision which lies in the Advocate's sole discretion.

In keeping with the foregoing, and after consultation with Lexi's family, the Advocate has decided to release this report with the following findings and recommendations. These findings are put forward as a record of our investigation and review and in support of our recommendations. They aim not to culpabilize or castigate anyone but to challenge all of us, and elected officials first and foremost, to give renewed attention and importance to combatting youth suicide and to supporting child and youth mental health services and investments in children and youth more generally. Our report has found that we have made significant progress as a Province already, for instance through the development of mobile crisis units and integrated service delivery. Nonetheless, we have an important challenge before us, that has been exacerbated by the current pandemic, and we need all professional groups and communities and families and youth themselves to work together with the shared goal of addressing and preventing more youth suicides from occurring.

A SUMMARY OF OUR FINDINGS: LEXI'S STORY

From the outset of this review, we have separated the issue of what happened to Lexi Daken in relation to her search for mental health and suicide intervention supports between August 2020 and February 24th, 2021, from the broader inquiry into youth suicide prevention and mental health services in the Province generally. This investigation has allowed us to make certain factual findings in relation to the chronology of events, as are set out below, as well as some material observations in relation to gaps in services and failings to fully respect Lexi's right to life and right to health.

Chronology of events:

From our review of Lexi Daken's case, one thing that stood out was how quickly her mental well-being started deteriorating. In August of 2020, Lexi began self-harming whenever she was overcome by her emotions. The self-harm quickly evolved into more dangerous efforts as three months later, Lexi secretly began to prepare a suicide plan. She ended up at the DECH emergency room in mid-November following her first attempt at suicide. During this hospital admission, Lexi was kept overnight in an emergency department examination room and seen by the hospital psychiatrist the following morning. This psychiatrist gave Lexi a diagnosis of Major Depressive Disorder with Borderline Personality Traits. He also referred Lexi to Integrated Service Delivery (ISD) and encouraged her to begin private counselling therapy. An administrative error resulted in mistakes in documenting both Lexi's father's phone number and the high school she attended. Consequently, Lexi's file was sent to the Oromocto Child and Youth ISD Team instead of the Fredericton North Child and Youth ISD Team. Due to having the wrong number, the ISD receptionist could not reach Lexi's father by phone to schedule her intake appointment and had to mail a letter instead. Because of these errors, Lexi missed out on an available Intake appointment 3 days following her hospital admission and had to wait one full month to meet with ISD. Fortunately, Lexi's father was able to initiate her sessions with a private counselling therapist without delay.

One week following Lexi's first overdose, her Leo Hayes High School guidance counsellor was made aware of her hospital stay at an Education Support Services meeting. After several attempts at trying to reach out to Lexi through friends and family, she eventually succeeded in meeting with her one week later and continued seeing Lexi every couple of weeks or on an as-needed basis.

During the ISD Intake appointment in mid-December, Lexi shared that she had been absent from school since her overdose one month ago. She was anxious about catching up on missed school work and was also very concerned about her peers learning about her recent hospitalization. Lexi's ISD file was transferred to the Fredericton North Child and Youth Team and assigned to a clinician as a high priority for weekly sessions. Upon assignment of Lexi's file, the ISD clinician - registered nurse - contacted Lexi's father on the same day and they agreed that once Lexi's private counselling therapy sessions ended, she would meet with Lexi.

After the holiday break, Lexi's condition continued to worsen. Her guidance counsellor made arrangements with school administration to relieve some of Lexi's stress by pro-rating her grades to her average earlier in the school year. She also arranged for a quiet room to be made available to Lexi on an as-needed basis. The ISD clinician again reached out to Lexi's father to encourage him to provide her with any updates and let her know when Lexi's private counselling sessions were complete. On February 10th, Lexi's father emailed to let the ISD clinician know that she had finished her last session. The ISD clinician replied that she would plan to see Lexi the following week and asked if she could contact the private counselling therapist in the meantime. During an Education Support Services meeting on this day, Lexi's guidance counsellor expressed urgency in having Lexi seen by ISD. Unfortunately, a week later the ISD clinician had still not seen Lexi.

On February 18th, Lexi went to see her guidance counsellor as she had been actively thinking about suicide despite having finished her therapy and being on antidepressants. She had also been sleeping very poorly for quite some time. Lexi disclosed her suicide plan. Her guidance counsellor was extremely concerned by this and asked Lexi if she felt safe to go home. Lexi wasn't sure about this and so they decided that they should go to the emergency room. The school administration had reservations about this decision as in past experience, previous attempts to take suicidal youth to the emergency department had been met with little success and often resulted in the youth feeling more hopeless. Nevertheless, the school administrator agreed that it was an appropriate measure as Lexi's safety was in jeopardy.

Of all the staff at the emergency department, the triage nurse was the most empathetic towards Lexi's condition and spent a lot of time to discuss what brought her into the ER that day. We have since learned that this nurse engages in self-directed learning on best practices working with patients who are suicidal or have a mental illness. She felt it was important and revealed that on some days in the DECH ER, about half of the patients presenting are there due to some form of mental health distress.

Lexi was triaged as a Level 3 (i.e. Urgent – Serious conditions that require emergency intervention according to the Canadian Triage and Acuity Scale) and placed in the general waiting room where she and her guidance counsellor waited close to 5 hours before being moved into an examination room. During this time, Lexi's father texted her guidance counsellor from the parking lot to say that he had arrived at the hospital. Lexi expressed that she preferred that her guidance counsellor remain to explain her concerns with the psychiatrist. The current COVID-19 protocol at the time only allowed for one person to accompany Lexi. Her father was okay with Lexi's request and her guidance counsellor agreed to keep him up to date with text messages.

At 6:26pm, an ER RN assessed Lexi and noted that she was experiencing suicidal ideation with hallucinations. She also recorded that Lexi had an eating disorder and a previous suicide attempt.

At 6:34pm, the ER psychiatric nurse was notified that Lexi was ready to be seen.

At 6:44pm, Lexi was moved into an examination room and it was an ER physician who came to see Lexi, not the ER psychiatric nurse.

At 7:14pm, Lexi was seen by an ER physician who asked Lexi's guidance counsellor what brought Lexi into the ER. The guidance counsellor said that Lexi was suicidal and had a serious attempt in November 2020. The physician asked what the goal was of bringing Lexi in. The guidance counsellor replied that she needed to see a psychiatrist. The physician asked Lexi if she could keep herself safe at home. She referred to this as *contracting to safety*[2] . Lexi could not agree to this and so it was noted in Lexi's chart that she could not contract to safety. The physician asked Lexi about her hallucinations and then ordered bloodwork (CBC, TSH and tox screen).

At 8:34pm, the physician came back to see Lexi as her bloodwork results were in and all was normal. The physician again asked Lexi if she went home, could she keep herself safe? Lexi hesitated, looked at her guidance counsellor and kind of smiled. Her guidance counsellor replied that she didn't think Lexi could keep herself safe. The physician indicated that if Lexi could not contract with them to keep herself safe, they would have to call in the on-call psychiatrist. Lexi's guidance counsellor reiterated that she felt Lexi needed to see a psychiatrist at which point the physician again asked Lexi if she could keep herself safe. Lexi replied, "I think I can...", "Yeah, I think I can." Her guidance counsellor asked, "Are you sure?" The physician wrote the Mobile Crisis Unit number for Lexi and said she'd set up an outpatient consult for a psychiatrist and that they were free to leave. Thanks to the interventions of her school guidance counsellor and administration and the emergency room triage and clinical team, Lexi did not die that day.

Lexi and her guidance counsellor met Lexi's father in the hospital parking lot where her guidance counsellor relayed the physician's words to him and said that she felt it was not an ideal way to present the options to a 16-year-old. She told him to keep a close eye on Lexi and encouraged Lexi to call her any time she needed to.

On the following day (February 19) at 9am, the ER physician's urgent psychiatrist referral was faxed to the Victoria Health Centre. This fax was then forwarded to Lexi's assigned ISD clinician and did not result in a psychiatry referral as intended.

On February 22nd, Lexi's ISD clinician attempted to see her at Leo Hayes but she was absent from school that day. She emailed Lexi's father to let him know and offered to see her at the ISD office at Nashwaaksis Middle School. He wasn't aware that Lexi wasn't at school that day and shared that she should be at school Wednesday and Friday. The ISD clinician said she would plan to see her that week.

At 4:10am on February 24th, 2021, Lexi was brought to the DECH ER following another suicide attenpt. She was pronounced dead at 10:42am.

The Advocate's material findings

It is not the Advocate's role to make findings of fault in order to support reparations or orders of compensation. The civil courts offer many remedies to address such matters. Nor is it our intention to lay blame at anyone's door in particular. Our review suggests that there is enough blame to go around in this matter for everyone to shoulder it. It is, however, the Advocate's mandate to defend the rights and interests of children, youth and vulnerable adults. It is our mandate to educate New Brunswickers about these rights and interests and to elevate the voices of children and young people, so that their opinions can be heard and considered in decisions which affect them.

And it is our mandate to ensure that children and young people have access to the programs and services to which they are entitled by law, as well as to provide advice to government on how to better enforce these rights and address these interests. Having reviewed all the circumstances of Lexi's passing, we come to the regrettable but inescapable conclusion that this death, like many youth deaths from suicide could have been prevented.

We know that no system is perfect and that addressing the problem of youth suicide is a challenging one which involves many players and many systems. But as one coroner told us, if every year a half dozen or more young people died in dentists' chairs, we would identify and address the problem fairly quickly. Others have reminded us that for fifty years we have focussed much energy in our health care system in addressing heart disease. As a result over fifty years the mortality rates due to heart disease have improved dramatically. Unfortunately, suicide has not had the same professional attention and the mortality rates for suicide have not improved at all. Why is it different with suicide? Some of the problems are obvious enough. We review below some of the material failures or errors that we noted in our review of file materials related to Lexi Daken's death. Some findings relate to human error, some relate to a failure to follow established protocols, some relate to a lack of adequate resources or resource management, some point to the need for more training and better protocols and safeguards. We have grouped these findings in relation to acute care in the emergency room department, in relation to community-based interventions through Integrated Service Delivery, and conclude with a few other findings that fall outside of these two main categories.

Acute care setting:

Our review found that DECH Emergency Department staff had little or no formal training and inadequate resources to support their working with mental health patients. Even the ER psychiatric nurses we interviewed had not received specialized training; they gained their knowledge through experience working on the inpatient psychiatric ward. The need for improved Mental Health training of all front-line staff working with children and youth was echoed repeatedly throughout our review, most cogently in the submission from the NB College of Psychologists (CPNB). None of the DECH employees interviewed, when asked about suicide risk assessments, could identify a standard tool that is routinely used on their patients. The ER physician, when interviewed by the Advocate, was also unfamiliar with suicide risk assessments. The CTAS – Canadian Triage Acuity Scale – does measure for suicidality and self-harm, but it mainly proposes a scale to rate physical pain intensity from 0-10 but does not account for psychological pain. The absence of an evidence-based prioritization assessment tool for patients in mental distress results in longer wait times for suicidal patients because they are not triaged as a high priority in terms of physical emergency.

Lexi had her guidance counsellor for support during her long wait, but many youths endure this wait alone. The ER social workers do not have specific responsibilities to support mental health patients; they are mostly involved with patient housing assistance and child protection cases. The lack of an available exam room to carry out an assessment was offered as one of the reasons why the day-shift ER psychiatric nurse was not able to assess Lexi following her admission. We also find that there was a lack of a standard protocol for suicidal patients who present to the DECH Emergency Room.

We were informed that some psychiatrists working on-call are reluctant to come in after midnight unless there is a serious mental health crisis situation. It was suggested that this may factor into the ER physician's willingness to consult them through the night. The fact that the ER physician left the decision up to Lexi of whether to consult the on-call psychiatrist is in our view unjustifiable. We find it noteworthy that Lexi did not "contract to safety" the first time she was asked by the ER physician on February 18th; she had a suicide attempt 3 months prior; she had a suicide plan and had gathered the means to execute it; she was actively having suicidal thoughts; she was experiencing very disturbing visual and auditory hallucinations; she had a family history of suicide; she was brought in by a concerned mental health professional; she was diagnosed with Borderline Personality Disorder traits and Major Depressive Disorder; yet was still sent home because she verbalized she would keep herself safe the second time the ER physician asked. Children should never be placed in these predicaments. They deserve better, more effective, connections to timely, compassionate care. Asking a young person to contract to safety when the youth presents with a history of suicide attempts, is actively suicidal and brought there by an educational specialist requesting an emergency admission and expert assessment, is contrary to health policy and practice and places an unfair and unreasonable burden of decision on the young person.

We find further that the DECH's discharge of a suicidal youth in this manner is compounded by a lack of proper assessment of her condition and safety planning. Lexi presented to the DECH emergency department with: depression, suicidal ideation (including a suicide attempt 3 months prior), anxiety, insomnia, history of self-harm, disordered eating and hallucinations (visual – large spiders and severed hands, and auditory – voices, banging pots and pans). Furthermore, the failure to involve Lexi's parents in the treatment plan is in itself concerning, while she was accompanied by her school guidance counselor, her father was waiting in the DECH parking lot, because of the COVID restrictions in place, and yet no effort was made to involve him or her mother in any risk assessment, safety planning or discharge. Lexi did not receive any formal suicide risk assessment, nor was she assessed by the ER psychiatric nurse or psychiatrist. Upon discharge from the ER on February 18th, she was given the number for the Mobile Crisis Unit and an urgent outpatient referral to see a psychiatrist. She was never given an opportunity to develop a safety plan, neither upon her first hospital visit in November, nor upon her second visit in February, nor at any point in between of after. If New Brunswick provided every youth with mental health challenges universal safety planning supports, that plan would be a constant in every clinical interaction in every case. ISD could easily integrate safety planning as a universal measure in common plans for youth with mental health challenges.

In our view, as happens all too often with youth presenting with mental health challenges, Lexi's right to health was compromised also by a failure to look into the underlying causes of her suicidal ideation or the co-morbid conditions that could have been impacting her health. In particular, Lexi's eating disorder went undiagnosed, yet she considerably restricted her food intake, well below recommended daily calorie requirements and had significant body image issues. Occasionally, treatment for disordered eating can include hospitalization, yet this was overlooked at Lexi's initial hospitalization in November 2020, and again on her trip to the emergency department on February 18th, 2021.

Community-based Care:

In relation to the help that she could and should have received from community-based teams, our findings while less glaring are nonetheless, no more encouraging. The ER physician had explicitly told Lexi and her guidance counsellor that she would hear from CMH in a day or two to book her psychiatry appointment, likely to occur in the following weeks. Had Lexi been given accurate information, it may have affected her decision to stay or leave that night at the ER. However, the ER physician informed us that they are not kept informed of current wait times to see a Community Mental Health psychiatrist. This lack of information flow from community-based mental health services to emergency room departments is one of the many ways in which we find that Integrated Service Delivery is not integrated at critical junctures. Guidance counsellors themselves must rely on their school's ISD Child and Youth Team member to share students' Horizon Health information and developments at bi-weekly meetings with the school's Education Support Services Team. Integrated Services Delivery needs to connect all professionals involved in a child or young person's care, from the classroom teacher to the emergency room, otherwise the integration and objective of wraparound services fails.

While we found that Lexi's school guidance counsellor stood out as someone who offered endless support and therapy, urging Lexi to contact her on an as-needed basis, even through the night, her position outside of the ISD inner team constituted a critical flaw in services. Even so, with a responsibility for 375 students and many in similar mental health crises as Lexi, how sustainable is even an exemplary counselor's remarkable level of commitment? And at what cost to her own mental health and ability to intervene effectively? According to Lexi's guidance counsellor: "So many kids are dealing with chronic trauma from childhood, and with very few coping skills. By the time they're in high school, they often require intensive therapy".

Lexi's case demonstrates how ISD child and youth teams need to work more closely with school-based teams and hospital-based teams to triage cases more effectively. ISD should be able to support crisis interventions more effectively, by relying upon supports for individual youth wherever they are, in school, in health care settings or in the community. More intensive supports are needed in schools to support youth with suicidal ideation.

The delays in accessing ISD supports that were apparent in Lexi's case are inexcusable in the face of her level of needs, even though multiple factors contributed to these delays (the Family Day holiday on Monday February 15th; the ISD clinician's full schedule of existing appointments with other clients; waiting for permission to contact the private counsellor; and the COVID-19 schedule of staggered in-class attendance). We ask in particular, considering the COVID crisis when telehealth solutions became much more commonplace, whether an initial virtual contact between ISD and Lexi should have been arranged.

Other:

Beyond these findings we have a few final observations unrelated to acute based care or community-based care. One important area is the need for improved post-vention support for hospital-based staff as well as school-based staff. School workers, as well as hospital workers and community based youth workers, who all work on the front lines of youth suicide response are very often victims of these tragic deaths as well. Like any other field of emergency response, there is a risk that the professionals involved in the care of young people who die from suicide will themselves suffer from the trauma of having witnessed or been unable to prevent this loss of life.[3] Suicide, and youth suicide in particular, will begin to abate and become less frequent as we learn to address its root causes more proactively and effectively. Supporting youth and health sector workers who are on the front lines of these traumatic events, so that the systems they work in can process the loss with dignity and resolve, but without trauma, helps create an environment for continuous learning and quality improvement. Health care excels in this kind of process improvement across health systems and youth suicide should not be the exception, but the exemplar of how we learn and adapt to health care challenges. This process of learning begins with effective post-vention supports not only for families and carers but for staff as well.

Another important finding is in relation to the Community Mental Health Standards. While Lexi was not able to benefit from timely access to mental health supports, the ten business days standard for access to care is in our view inadequate for young people presenting with suicidal intent and should be reviewed. A ten day standard for a connection to care for a suicidal patient is questionable at any age, but we believe the Province can and must aim higher and demand of the health sector a more rapid and timely access to care for child and youth mental health patients in general and an expedited or immediate connection to care for suicidal youth.

SYSTEMIC REVIEW FINDINGS

Many of the recommendations which will follow below stem from the individual case study findings outlined above in relation to the care offered, or not offered, to Lexi and her family. Often the flaws in any given system become apparent following a thorough case study of an individual patient file as outlined above. Unfortunately, the system failings evident in Lexi's case were mainly not circumstantial; they are corroborated by the numerous similar trajectories shared by other New Brunswick youth and families in our broader systems review.

History of Mental Health Services and past recommendations and reviews

Our Review presented a unique opportunity in the Advocate's fifteen-year history to revisit some of our past recommendations and those from other departmental and external reviews related to mental health services for youth in New Brunswick and monitor the progress of their implementation. While we find that some progress has been made in important aspects of care, on balance the government's record on the uptake, implementation and follow through of recommendations made is rather more negative than positive. As a provincial Advocate for children and youth, we recognize our share of responsibility and recommit ourselves to finding better ways to hold government accountable for the undertakings they give us in following through on recommendations made. Other Advocates offices in Canada and other legislative officers in New Brunswick, notably the Attorney General, have much better systems for tracking recommendations and dedicated staff positions assigned to these functions. We intend to model our practice upon theirs in the months ahead and invest more effort in ensuring that recommendations are followed.

In our interim report we have already commented upon the worst example of inconsistent follow through relating to the challenges in developing a specialized acute care centre for step-up interventions and clinical direction of step-down interventions for the province's hardest to serve youth and most complex cases. Unfortunately, many other examples exist. The *Staying Connected* report from 2011 which provided the road map for a proposed Centre of Excellence for children and youth with complex needs is still waiting upon implementation despite its approval, endorsement and efforts by every government elected in the last twelve years. But beyond proposing a road map for such a centre, the Staying Connected report also recommended a new community-based service orientation that the proposed reform should take. In 2011, it was anticipated that the proposed centre would provide clinical supervision to a network of local therapeutic foster homes, that it would have the lead responsibility for the clinical supervision of discharge and step-down interventions, that it would support families with respite services and localized training and education, that it would provide clinical supervision to ISD Child and Youth teams and Integrated Clinical Teams, that the training programs offered through the Centre of Excellence and in collaboration with two university research chairs would provide year-round cross-sectoral training supports to primary care professionals, mobile mental health crisis units, community youth justice committees and local autism centres.

Because the Centre of Excellence never materialized, the professional clinical direction to coordinate services through improved community-based mental health supports also never occurred, and yet this could have been done through a better coordination between the CRISMEJ research chair at the Université de Moncton, the Child and Adolescent Psychiatric Unit at the Moncton General Hospital (CAPU), the Pierre Caissie Centre and the youth unit at the Restigouche Hospital Centre. Today, ten years after our recommendations, the Minister of Social Development has finally announced the creation of therapeutic specialized care homes and the stepped care model of intervention called for in *Staying Connected* is now being implemented in New Brunswick based upon a model from Newfoundland and adapted from the UK but which also drew, at least in part, from recommendations and early efforts at service integration for complex needs youth in our own province.

Judge Mckee's report, *Together into the Future*, from May 2008, also pointed to the promise of improved community-based care. Shortly after its release, Judge Mckee founded in Riverview the Atlantic Wellness Centre. They have since grown from a small operation with two clinicians to a team of eight counsellors providing free access to licensed counselling supports for any child or youth across southeastern New Brunswick who seeks their services. It offers a clear example of how community-based supports can move in nimbly and provide much needed supports with the help of local philanthropy in a timely fashion.

We salute also the clinicians we have found throughout this review who are pushing the frontiers of formal systems of care to develop more accessible, more expert and timely interventions for children and youth with complex needs. NB Pediatricians have developed promising models of social pediatrics in community with guidance from the Foundation Dr. Julien in Quebec. Other clinical experts and community sector professionals have pioneered child and youth advocacy centres providing wrap-around community-based supports for child victims of abuse. Academic researchers and community partners have lead ACCESS Open Mind pilot sites to deliver wrap-around community-based supports to youth seeking access to mental health services. All of these initiatives have proven the worth of community-based care.

What we now need are mechanisms that allow government and formal systems of care to financially support the community-based capacity that is trusted and most accessible to youth at the local level. We also need mechanisms to integrate this trinity of i) acute-based tertiary care and specialist care through hospital based and clinical settings, ii) formal systems of primary care through primary health and ISD, and iii) community-based care. Each of these pillars of intervention must remain distinct and separate, but they need to work seamlessly as one to give children and youth the hope they need.

The history of youth mental health service provision in New Brunswick shows that the problem does not lie in a lack of awareness, nor does it lie in a lack of available innovative solutions, nor does it lie so much, as we once thought, in a lack of political will. Our review posits as one of its main findings that the lack of measurable and more meaningful progress on this file in New Brunswick stems from a lack of clear lines of responsibility and accountability for children and youth in the machinery of government. In our 2008 *Connecting the Dots* report, we recommended the establishment of a Minister for Children and Youth supported by a small department to coordinate and ensure quality of services for children and youth across the provincial government and with other levels of government. This mechanism for horizontal management of services for children and youth across government remains as pressing as ever.

The Women's Equality Branch, the Department of Aboriginal Affairs, or the Premier's Council on the Status of Disabled persons all provide good models for development in this regard.

Our findings in this regard are supported materially by the ongoing challenges that have plagued the provincial roll-out of Integrated Service Delivery. ISD is without a doubt the most significant system change in child and youth service delivery since the educational reforms of the Equal Opportunity Program 50 years ago. While the term Integrated Service Delivery was coined here in New Brunswick, it has since been taken up in the literature and in policy circles across the country. ISD has been celebrated as a national best practice[4]. It has succeeded in creating wrap-around supports for complex needs youth through a school-based and clinically led intervention that can triage needs as they present and coordinate services across all of government. We did hear in our review from a number of youth and a number of families who were supported through ISD interventions and described the supports as life-saving. When it works well, ISD works very, very well.

Our review has found, however, that ISD is not working very well in many parts of the Province. Instead of guaranteeing the right intervention at the right intensity at the right time for every child as once envisioned, ISD is in many places now offering only a local step-up intervention for very complex youth, if the case is successfully triaged and referred. In this respect, ISD has in some places become a new form of siloed care, or another instance of the very problem it was intended to resolve. The wait times for accessing ISD are growing longer and longer. Child and Youth team doors are often closed and inaccessible to students in schools where they are located. Some school officials in southern New Brunswick have informed us that despite repeated attempts none of their school's referrals to ISD have been accepted over four years and that the school administration has simply stopped referring cases, as they have concluded that no supports are available from ISD to their students.

This experience lies in stark contrast with that of communities where local child and youth teams have assigned leads to work with school-based Educational Support Services ESS teams, where cases are constantly triaged, referred and reassessed based upon evolving needs, where guidance counsellors are working in step and with the clinical support of Child and Youth team clinicians. The problem is that ISD has not enforced effective standards of practice and the fidelity to the intended model of intervention varies across the Province. This problem was pointed out in our interim report and is already being addressed. We find however that this corrective measure will not suffice, ISD also lacks outcome measures and key performance indicators as well as a policy framework to ensure stability of interventions over time and across services. The existing governance structure has also not served the model well. Since the provincial roll-out of ISD in 2008, the unit responsible for its implementation has been reduced from a staff of five persons, to only two. They still operate from a middle management unit within the Department of Education and Early Childhood Development, but a great many of the senior managers and the political leaders who championed the ISD transformation exited en masse in 2018, in a perfect storm of a change of government, an unprecedented pandemic and a weak process for succession planning on this important file. Our conclusion from this review is that while ISD provides a theoretically sound model for improved service delivery, has been critically acclaimed, had proven results leading up to its provincial roll-out and is making a positive difference in many lives in New Brunswick (the number of youth accessing services and seeing a clinician has more than doubled since the ISD model rolled out provincially from just over 4000 clients annually to almost 8500 in 2018-19), at this point the multi-million dollar system transformation invested in by successive governments is at the point of faltering because of the lack of a robust centre of responsibility for such an important systems change across numerous departments and agencies of government.

More than anything, our review of the history of mental health services for children and youth in New Brunswick points to a lack of sustained effort, funding, accountability and strategic planning over time. This more than anything in our view explains why we are confronted time and again with many of the same issues, seemingly without progress, despite fairly constant efforts. We believe that by following the path outlined below, founded upon child rights-based approaches and the Availability, Accessibility, Acceptability, Quality (AAAQ) Framework, we can stop this cycle of history repeating itself. The path forward must also begin with a sound knowledge of the data picture surrounding child and youth mental health and suicide in New Brunswick.

Clinical Issues, Statistics and Population Wellness

Childhood and adolescence are periods of turmoil and significant developmental changes; socially, physically, and emotionally. The onset of many mental illnesses and mental health issues only adds to this period of mayhem. A majority (70%) of mental illnesses have their onset during adolescence and 1/5 of Canadian youth have a diagnosed mental disorder.[5] This highlights how imperative early interventions and access to mental health services are. Many youths also present with suicidal ideation, suicide attempts, and self-harming behavior for the first time during this period. For young people between 15 and 19 years of age, suicide is the second leading cause of death after accidents.[6] This is the third highest youth suicide rate in the industrialized world. Oftentimes, suicide and mental illnesses are interrelated such that youths who attempt suicide are also struggling from a diagnosed or undiagnosed disorder. Unfortunately, despite these alarming statistics and prevalent issues, access to mental health services and wait times for counseling and psychotherapy remain a serious problem in our province.

Alarmingly, suicide rates are significantly higher among First Nations and Inuit populations. According to Health Canada, the suicide rate for First Nations youth under 19 years of age is estimated to be five to seven times higher than the suicide rate of other Canadian youth, while Inuit youth suicide rates may be 11 times higher than the national suicide rate.[7]

According to the Child Rights Indicator Framework, 72% of New Brunswick youth aged 12 to 17 rate their mental health as very good to excellent.[8] This compares with the national data which is virtually identical at 73%.[9] Inversely, almost 38% of New Brunswick youth in grades 6 to 12 report having had symptoms of anxiety in the past twelve months compared to a Canadian average of 34%.[10] The literature review undertaken for the purpose of this review found that promoting mental wellness and resiliency is an important suicide prevention strategy. Mental wellness encompasses emotional, spiritual and mental/intellectual development. Additionally, mental fitness refers to our personal sense of psychological wellness such as, thoughts and feelings.[11] We are most likely to be mentally fit when our needs for competency, autonomy and relatedness are met. It means having a positive sense of how we feel, think and act, which improves our ability to enjoy life.[12] It also implies the ability to efficiently respond to life's challenges and to effectively restore and sustain a state of balance.[13] This is why it is vital to have adequate mental wellness programs in the community and in schools to support children and youth.

Mental wellness is also heavily influenced by one's environment. An environment that satisfies the three following psychological needs increases an individual's motivation, engagement, and likelihood of making healthy lifestyle choices: competency, autonomy, and relatedness.[14] Wellbeing is a complex combination of a person's physical, emotional and social health factors and is not simply the absence of diseases or illnesses.[15] Physical well-being is a critical social determinant of health and wellness for children and youth and so mental wellness programs aimed at addressing psychological needs must be premised upon a social welfare net that looks to even more basic needs providing every child with a safe home, a safe neighborhood, nutritious meals and a nurturing home and community environment that fosters play, rest and opportunities to take part in sports, recreation, and local arts and culture. The promotion of mental wellness is essential in order to provide youth with the appropriate coping mechanisms and strategies.

Resilience is often used to describe the ability to recover from difficult life experiences or mental health challenges and plays a key role in an individual's mental wellbeing. An individual's resiliency does not refer to a one-time event but instead to an ongoing process that develops as we experience emotional pain and distress, and develop strategies that help us cope and respond to difficult events.[16] We have learned from the Adverse Childhood Experiences (ACEs) studies that trauma in young years can often manifest as mental health challenges in adolescence or later in life. And yet the same studies show that a significant proportion of children with adverse childhood experiences manage to thrive and avoid later health complications. Encouraging high resilience is an important part of combating mental health challenges, particularly in youth as they develop. Strategies for building high resilience may differ from one individual to the next, but good mental health and resilience are inextricably connected. The Centre for Addiction and Mental Health in Toronto provides good resources to help parents raise resilient children and youth. Their proposed approaches look at individual factors, family factors, and environmental factors that contribute to good mental health and resiliency in children and youth and provide helpful strategic direction for service providers in New Brunswick.

Statistics on child and youth mental health and suicide are not always easily accessible to the public[17]. The Government of New Brunswick, in particular Child protection services under the Department of Social Development, has limited resources or data regarding child abuse, neglect, mental health status, and suicide attempts. The Department of Social Development does not effectively track and monitor the number of cases where child victims have suffered neglect, physical abuse, sexual abuse or psychological maltreatment. This is concerning because the department does not have a thorough understanding of the issues within the child welfare system even though the social workers may have knowledge of many of these issues as a result of working on the front lines. A better tracking mechanism for child abuse and neglect is needed for intervention purposes.

A critical indicator in the Advocate's efforts to improve mental health outcomes for young people over the past number of years, through the CRIF has been the number of hospitalizations by mental health diagnosis. When we compare ourselves to other Canadian jurisdictions or to the national data on these fronts, we find that youth in New Brunswick are much more likely to be admitted to hospitals than their Canadian peers. In 2019-20 according to the latest CRIF data we see a rate of hospitalization of 47 youth per 10,000, all mental health diagnoses and disorders combined, compared to a national hospitalization rate of 34 per 10,000.[18]

A hospitalization rate 40% higher than the national average is costing us dearly both in terms of financial outlay and improved clinical results. We know that hospital-based care is often sought and delivered as a crisis-based intervention following a lack of successful prevention efforts at the community level. Hospital-based interventions are the most expensive interventions, they arise late in time and generally have poorer outcomes than early interventions. Our Child and Youth Mental Health Strategy needs to be squarely targeted towards shifting the focus away from expensive, often less effective, hospital-based interventions and supporting more early intervention at the community level. We should not be aiming only to align with the Canadian average. We need to surpass it and be leading the country as early adopters of prevention and early intervention community-based care.

The Stepped Care Model is an excellent strategy to help the Province reach this goal. It needs however, to be adapted within a targeted Child and Youth strategy. The recent Mental Health Action plan itself underscores this need when it points out in its opening passages and its Appendix B that in the past five years new referrals in mental health and addictions from youth have significantly outpaced the increase in demand on the adult side, such that youth now represent almost half of all referrals compared to merely a third of referrals five years ago. Last year the overall referral numbers actually declined for both adults and youth, but this dip is explained by the social isolation impacts and the challenges in accessing formal systems of care during the pandemic. Other data, for instance from Kids Help Phone points to a massive uptick in mental health support requests from children and youth across the country, including New Brunswick. Recent reports suggest the pandemic impacts have led to a doubling of reports of anxiety and depression among teens and may be particularly strongly felt by older adolescents and girls.[19] The Canada Suicide Prevention Service has also seen an increase in volume since the start of the pandemic, with about 50% more interactions compared to the same time last year. They were seeing more intense interactions as well and have had a 62% increase in active rescues (when responders call emergency services due to an imminent risk of harm or a suicide in progress) - two trends that seem to be accelerating.[20]

We should not be waiting for these cases to show up in emergency following months delay in community-based care. We should be acting proactively now to meet this demand for mental health supports at an early intervention level before things escalate. Our recommendations to government in this regard are informed by a detailed background paper that looks to the anticipated impact of the COVID-19 pandemic and public health measures taken in response on the demand for child and youth mental health services. All the research is pointing to a need for increased resources in this area immediately and for the following number of years.

We find that increased opportunities for community, youth and families to interface with health system administrators and other child and youth services officials with the Advocate's Office to review the annual data, monitor progress and correct policy and practice interventions, as well as efficient resource allocation decisions, in a process of continuous improvement would be very helpful. This finding is supported by the expert evidence made available to us by government departments themselves and which recognize the need for more sustainable youth and family engagement in planning mental health service delivery for children and youth.[21]

Human Rights and Legal Framework

The child and youth mental health services system in New Brunswick, like all public services, exists within a legal framework. The *Health Services Act*, prescribing medically insured services and the *Regional Health Authorities Act* and *Hospital Services Act*, regulating the establishment and governance of community health centres and hospital-based care, provide the legal framework regulating the provision of health services in New Brunswick. Mental Health Services are also governed by the *Mental Health Act*, governing voluntary and involuntary placements of mental health patients in psychiatric facilities or approved homes and regulating the management of their assets and goods in case of incapacity and by the *Mental Health Services Act* establishing a citizen led oversight body for quality assurance and good governance of community-based mental health services. The *Education Act* and the Child protection provisions of the *Family Services Act* also have some incidence in relation to services to children and young people at risk of suicide and struggling with the onset of mental illness. Federal legislation governing youth criminal justice administration or services to First Nations children and youth has some bearing on these issues as well. All of these laws are governed by our Constitution and must comply with the human rights guarantees set out in the *Canadian Charter of Rights and Freedoms*. The Charter in turn is interpreted in keeping with our international human rights obligations which form part of the Rule of Law, a governing constitutional principle. The need for public services to be circumscribed by statute and the need for such laws to conform with certain constitutional constraints including an overarching human rights framework is well understood by all legal professionals.

Public administration experts, using systems theory, understand these concepts as well. In Nova Scotia, Todd Leader has had great success in transforming mental health services through client centred approaches[22]. In New Brunswick the Advocate is calling for child rights-based approaches to ensure that every child's claim for services are met with the compassion and human dignity they deserve. Essentially, the thrust is the same, one is a performance management systems based approach to reform, the other is a human rights based approach. They both involve reorienting all of our interventions from the root premise that systems have before them a human being, in many cases, a child or adolescent, whose particular needs must be met. Social scientists also understand this core deliverable and frequently reference Urie Bronfenbrenner's ecological model which explains how an individual relates to and operates within the world around them by reference to concentric circles of supports, stemming from kinship supports, to community-based supports through school, work or church, to formal system supports such as hospital services, municipal services and public services generally to a legal framework that is itself premised on overarching normative values and human rights principles. Human rights analysis and child rights-based analysis is therefore the ultimate accountability mechanism to make sure that governments and public service providers, including health care systems, are accountable to their patients and respectful of the universal human rights and guarantees to which our legal systems and public services are intended to give effect. Unfortunately, in New Brunswick, as in much of the rest of Canada, the connection between human rights and health services often goes unnoticed. Our Review has confirmed that even at the highest levels of public administration in our Province, the obligation of all health service providers to comply with universal human rights obligations to children and young people is poorly understood and not always viewed as a helpful analytical lens.

The Advocate however has the legislative mandate to uphold and protect the rights and interests of children and young people and their rights are well established under the UN Bill of Rights and under the UN Convention on the Rights of the Child in particular. The UN Committee on the rights of the child has returned to the important issue of child and youth mental health in no less than four General Comments since 2001. General Comment No. 4 on *Adolescent Health and Development* (2003), General Comment no. 9 (2006) on the *Rights of Children with Disabilities*, General Comment no. 15 on the *Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* (2013), as well as General Comment no. 20 on the *Implementation of the Rights of the Child during Adolescence* (2016) all provide important guidance in relation to State obligations to children and young people in relation to mental health services.

As early as 2003, the Committee drew attention to its preoccupation with the rise in youth suicide in a number of countries around the world, with self-harm and an increase in anxiety and depression diagnoses in youth. The Committee urged governments to uphold their obligations to children and young people under Article 24 of the Convention, guaranteeing the right to the enjoyment of the highest attainable standard of health, "to provide adequate treatment and rehabilitation for adolescents with mental disorders, to make the community aware of the early signs and symptoms and the seriousness of these conditions, and to protect adolescents from undue pressures, including psychosocial stress."[23] The Committee also insisted on the right of youth mental health patients to be treated fairly without discrimination and to "be treated and cared for, as far as possible" in the community where they live.[24] They emphasized that hospitalization or placement in psychiatric facilities should be carried out only when necessary in accordance with the youth's best interest; that such placement should not disrupt other essential rights of young people including their right to education and access to recreational activities; and that in such placements, children and youth should be separated from adults, have access to an advocate and the right to periodic review of the conditions of their placement in accordance with Article 25 of the Convention.

Very helpfully, for our Review of Youth Suicide Prevention and Mental Health services for children and youth, the UN Committee underscores the normative content of Article 24 guaranteeing the Child's right to health and provides specific guidance to governments around the world on how to engage children in its implementation and what they must do to uphold this right. [25]

39. ... It is the view of the Committee that States parties must take all appropriate legislative, administrative and other measures for the realization and monitoring of the rights of adolescents to health and development as recognized in the Convention. To this end, States parties must notably fulfil the following obligations:

> ***(a) To create a safe and supportive environment for adolescents, including within their family, in schools, in all types of institutions in which they may live, within their workplace and/or in the society at large;***
>
> ***(b) To ensure that adolescents have access to the information that is essential for their health and development and that they have opportunities to participate in decisions affecting their health (notably through informed consent and the right of confidentiality), to acquire life skills, to obtain adequate and age-appropriate information, and to make appropriate health behaviour choices;***

(c) To ensure that health facilities, goods and services, including counselling and health services for mental and sexual and reproductive health, of appropriate quality and sensitive to adolescents' concerns are available to all adolescents;

(d) To ensure that adolescent girls and boys have the opportunity to participate ac-tively in planning and programming for their own health and development;

(e) To protect adolescents from all forms of labour which may jeopardize the en-joyment of their rights, notably by abolishing all forms of child labour and by regulating the working environment and conditions in accordance with international standards;

(f) To protect adolescents from all forms of intentional and unintentional injuries, including those resulting from violence and road traffic accidents;

(g) To protect adolescents from all harmful traditional practices, such as early mar-riages, honour killings and female genital mutilation;

(h) To ensure that adolescents belonging to especially vulnerable groups are fully taken into account in the fulfilment of all aforementioned obligations;

(i) To implement measures for the prevention of mental disorders and the promo-tion of mental health of adolescents.

The Committee insists further upon the need for coordinated approaches across government and between public services and community-based services "facilitating effective and sustainable linkages and partnerships among all relevant actors" using multisectoral approaches. The Committee further urges governments to give effect to Articles 24 and 39 of the Convention; they must provide health services that are sensitive to the particular needs and human rights of all youth by paying attention to the human rights criteria for accountable health services in accordance with the following AAAQ Framework characteristics:

(a) **Availability.** Primary health care should include services sensitive to the needs of adolescents, with special attention given to sexual and reproductive health and mental health;

(b) **Accessibility.** Health facilities, goods and services should be known and easily accessible (economically, physically and socially) to all adolescents, without discrimination. Confidentiality should be guaranteed, when necessary;

(c) **Acceptability.** While fully respecting the provisions and principles of the Convention, all health facilities, goods and services should respect cultural values, be gender sensitive, be respectful of medical ethics and be acceptable to both adolescents and the communities in which they live;

(d) **Quality.** Health services and goods should be scientifically and medically appropriate, which requires personnel trained to care for adolescents, adequate facilities and scientifically accepted methods[26].

In 2006 the committee produced a general comment on Article 23 of the 1989 Convention, the first international legal provision proclaiming the rights of person with disabilities, in this case children. General Comment No.9 refers back to General Comment no. 4 and exhorts State Parties to the Convention to keep in mind this guidance when they develop budgets, laws, remedies and educational and administrative programs giving effect to the rights of children with disabilities so that their developmental needs in adolescence are given particular consideration.[27] The Committee in detailing the obligations of governments in relation to the right to health of youth with disabilities insists upon prevention, early identification and intervention and multidisciplinary care, insisting that: "Children with disabilities very often have multiple health issues that need to be addressed in a team approach. Very often, many professionals are involved in the care of the child, such as neurologists, psychologists, psychiatrists, orthopaedic surgeons and physiotherapists among others. Ideally these professionals should collectively identify a plan of management for the child with disability that would ensure the most efficient healthcare is provided."[28] When ISD was first envisioned in New Brunswick it held out the hope of intervening with all children with special needs. Today we hear however that it is increasingly a resource only for youth facing mental health challenges. This slippery slope may have been engaged, because of the clinical expertise hired to direct ISD, or because of the pressing number of cases waiting for services in this sector. If however, we take a child rights based approach we must admit that one disability does not outweigh another, that all vulnerable children deserve the benefit of multisectoral approaches, and indeed that children with physical disabilities or neurodevelopmental delay may experience increased risk of mental health challenges or suicidal behaviour. In New Brunswick we should improve the opportunities to have all professionals involved in challenging pediatric disability case management participate in ISD processes and multidisciplinary approaches.

In its more recent General Comment on the Right to the enjoyment of the highest attainable standard of health in Article 24, the Committee confirms governments' obligations to provide young people with health services that respect the criteria of Accessibility, Availability, Acceptability and Quality. Moreover they provide a helpful description of the normative content of Article 24 by insisting that the health guarantee afforded to children and youth is comprised of rights and liberties, and that as children mature, their autonomous control and agency over health care direction and their own path to recovery grows with them. The Committee provides guidance for parents in implementing the right to health care and sets out the obligations in health care under the Convention for both State actors and non-state actors including academic research and philanthropy. Finally, it proposes a Framework for Implementation and Accountability that can serve as a very helpful guide in developing a new strategy and governance model for youth mental health services and suicide prevention in New Brunswick:

> 90. Accountability is at the core of the enjoyment of children's right to health. The Committee reminds the State party of their obligations to ensure that relevant government authorities and service providers are held accountable for maintaining the highest possible standards of children's health and health care until they reach 18 years of age.

91. States should provide an environment that facilitates the discharge of all duty bearers' obligations and responsibilities with respect to children's right to health and a regulatory framework within which all actors should operate and can be monitored, including by mobilizing political and financial support for children's health-related issues and building the capacity of duty bearers to fulfil their obligations and children to claim their right to health.

92. With the active engagement of the Government, parliament, communities, civil society and children, national accountability mechanisms must be effective and transparent and aim to hold all actors responsible for their actions. They should, inter alia, devote attention to the structural factors affecting children's health including laws, policies and budgets. Participatory tracking of financial resources and their impact on children's health is essential for State accountability mechanisms.

Finally, the most recent general guidance provided by the Committee on the Rights of the Child on this issue of child and youth mental health and suicide prevention can be found in General Comment 20 *On the Implementation of the Rights of the Child during Adolescence*. The advice from committee members rings particularly true as we think about Lexi Daken and the many early and late adolescent teens experiencing the onset of mental illness.

9. Adolescents are on a rapid curve of development. The significance of the developmental changes dur-ing adolescence has not yet been as widely understood as that which occurs in early years. Adolescence is a unique defining stage of human development characterized by rapid brain development and physical growth, enhanced cognitive ability, the onset of puberty and sexual awareness and newly emerging abilities, strengths and skills. Adolescents experience greater expectations surrounding their role in society and more significant peer relationships as they transition from a situation of dependency to one of greater autonomy.

13. Although adolescence is generally characterized by relatively low mortality compared to other age groups, the risk of death and disease during the adolescent years is real, including from preventable causes such as childbirth, unsafe abortions, road traffic accidents, sexually transmitted infections, including HIV, interpersonal injuries, mental ill health and suicide, all of which are associated with certain behaviours and require cross-sectoral collaboration.

56. Health services are rarely designed to accommodate the specific health needs of adolescents, a prob-lem that is compounded by the lack of demographic and epidemiological data and statistics disaggregated by age, sex and disability. When adolescents seek help, they often experience legal and financial barriers, discrimi-nation, lack of confidentiality and respect, violence and abuse, stigma and judgmental attitudes from health-care personnel.

In discussing with the Coroner's services their findings from an on-going forensic psychology report of recent youth suicides in New Brunswick, we find that many of the youth who die by suicide and those who attempt it present multiple, but preventable risk factors such as conflictual family dynamics, body image issues, unaddressed past trauma and social isolation, as identified years ago by the Committee on the Rights of the Child. Importantly, the Coroner's study will show that most completed youth suicides are preceded by previous unsuccessful suicide attempts.

A 'practice point' article on the topic of suicidal ideation and behaviour published by the Canadian Paediatric Society similarly acknowledges that "[a] previous suicide attempt is one of the strongest predictors of suicide during adolescence, and lifelong."[29] This only underscores the importance of intervening effectively with youth survivors of prior suicide attempts.

Our review of youth mental health services and suicide prevention services has found that many of the rights-based approaches suggested by the United Nations Committee on the Rights of the Child are being implemented in New Brunswick. The investment in Integrated Service Delivery, the commitment to trauma informed practices, the investments in quality of life in early years, can all be celebrated as examples of this. Unfortunately, none of these service transformations are being undertaken out of a sense of obligation as duty bearers to children and young people as rights-holders. Health professionals and their allies in education, child protection, or justice services have received little or no training to equip them with even a basic understanding of child rights-based approaches or analysis, or how it can be applied in their day-to-day work. There is no strategic plan for the enforcement of these rights in the health sector or elsewhere, although one was attempted in 2015 in child protection matters. Accountability mechanisms for rights implementation to ensure that programs and policies are adequately resourced, meet desired outcomes and include children and young people as participants are also lacking.

The Advocates office does publish an annual State of the Child report with its companion Child Rights Indicator Framework. The Province is still engaged in requiring Child Rights Impact Assessment as part of its provincial policy development process at the Cabinet level. Unfortunately, our attempts to engage stakeholders, even at the highest levels of administration, in New Brunswick in a recommitment to health care delivery that respects the fundamental rights guaranteed to children and young people were sometimes met with incomprehension and only rarely with encouragement or enthusiasm. We recognize that culture change is a slow and organic process, yet successive New Brunswick administrations have made new commitments to rights-based approaches, that are the seeds of sustained child rights enforcement such as we now see in Belgium, in Scotland, in Wales and in many other advanced economies and jurisdictions like ours. New Brunswick children and youth will have brighter futures if we remain committed to this path of slow but steady measured progress in programmatic rights implementation.

Social, economic and cultural rights, like the right to health, are referred to as programmatic rights because their realization depends upon planned government action to deliver essential public services. Our governments have ever since the second world war made this solemn commitment to programmatic enforcement of human rights not only because of our obligations to future generations but to past generations as well. This year in its bi-annual congress the Association des ombudsman et médiateurs de la francophonie, of which we form a part, adopted a resolution committing itself to support and defend the rights and interests of future generations. In our view this work on behalf of future generations begins with the seeds of hope, the paths to wellbeing and the knowledge of their rights needed to act towards others with peace, tolerance and fraternity that we impart upon children and young people today.

57. Adolescents' health outcomes are predominantly a consequence of social and economic determinants and structural inequalities, mediated by behaviour and activity, at the individual, peer, family, school, community and societal levels. Accordingly, States parties, in collabora-tion with adolescents, should undertake comprehensive multi-stakeholder reviews of the na-ture and extent of adolescent health problems and the barriers they face in gaining access to services, as a basis for future comprehensive health policies, programmes and public health strategies.

58. Mental health and psychosocial problems, such as suicide, self-harm, eating disorders and depression, are primary causes of ill health, morbidity and mortality among adolescents, particularly among those in vulnerable groups. Such problems arise from a complex interplay of genetic, biological, personality and environmental causes and are compounded by, for ex-ample, experiences of conflict, displacement, discrimination, bullying and social exclusion, as well as pressures concerning body image and a culture of "perfection". The factors known to promote resilience and healthy development and to protect against mental ill health include strong relationships with and support from key adults, positive role models, a suitable standard of living, access to quality secondary education, freedom from violence and discrimination, opportunities for influence and decision-making, mental health awareness, problem-solving and coping skills and safe and healthy local environments. The Committee emphasizes that States should adopt an approach based on public health and psychosocial support rather than overmedicalization and institutionalization. A comprehensive multisectoral response is need-ed, through integrated systems of adolescent mental health care that involve parents, peers, the wider family and schools and the provision of support and assistance through trained staff.

A previous generation of New Brunswickers knew and understood this mission full well, because they had fought the battles for freedom and liberty through which this very mission was forged. John Peters Humphrey, born in Hampton New Brunswick, set the course for the *New World Order* when he penned the first version of the document that would become the *Universal Declaration of Human Rights*. Other New Brunswickers, of every political affiliation, championed Humphrey's vision: Gordon Fairweather, as Attorney General for New Brunswick, under Premier Hugh John Flemming, and later as the First Chairperson of the Canadian Human Rights Commission, Louis Robichaud, Premier and author of the Equal Opportunity Program, Senator Noel Kinsella, as first Chairperson of the New Brunswick Human Rights Commission and later Speaker of the Canadian Senate, all played leadership roles in reinforcing New Brunswick and Canada's principled commitment to human rights enforcement. It remains both a debt we owe to those who sacrificed their lives for this vision and an obligation we owe to future generations to make the world we inherited a better place.

Today, less and less of us are aware of the overarching human rights framework that forms the foundation of our legal system and our public administration. Even as we strive to be ever more attentive to racial intolerance, to the impacts of colonialism, to the need for true gender equality, we distance ourselves and may even become openly critical of the normalizing impact of human rights discourse. This is especially true for children, who often remain bonded to adults who insist on making decisions for them, rather than teach them how to make good decisions for themselves. Paternalism is like a bad cold, it drags us down like nothing else, but keeps reoccurring.

And yet our Review has also given us moments of real hope. The early childhood educators who are not just suggesting or advocating, but are actively demanding change, not in adolescence services but for young children in order of priority, so as to take preventive approaches and interventions to avoid the hurt and trauma that may lead to poor mental health later in life. They are human rights defenders. The guidance counsellors who do not accept a delay or a service denial when it impacts a student in their school, but march with the student as an ally to the point of service demanding their right to health care. They are human rights defenders. The emergency ward nursing staff who take time to listen, who comfort and check back with youth who present with suicidal thoughts, who understand that human dignity requires their caring presence and support with this young patient despite the other pressing demands of the ward. They are human rights defenders. The retired civil servants who, after years of work promoting and advancing the interests of young people, write to urge us to call upon government for rights-based approaches to reform, not in one department, but across all government departments. They are human rights defenders. The parents who endure abuse or belittlement by an adolescent acting out but who continue to seek professional help and guidance to help them better support the child they love, but no longer recognize. They are human rights defenders. The young people who have been belittled and denied services in moments of real anguish, refused the caring presence of their parents, isolated and left alone in hospital with their suicidal thoughts and then discharged without guidance and without having seen a specialist, but who have survived and come forward to demand better services, so that no young person should endure what they have endured. They are human rights defenders.

Our recommendations below are premised upon the view that if more of us can step up to our role as duty bearers to children and young people, if we coach ourselves to understand young mental health patients and suicidal youth as rights-holders, if we hold ourselves accountable to those rights holders by following the guidance and advice from the global treaty bodies, we will be able to make swift and measurable progress on paths we are already on, but for which we have been lacking a destination, a map and compass.

Indigenous Youth Mental Health and Health Equity

As part of our Review Process the Advocate's Office established, at the prompting of our Advisory Board Co-Chair, Graydon Nicholas, a First Nations Advisory Council. This Council is comprised of Indigenous and non-Indigenous professionals, service providers and policy analysts and supported by Hans Martin Associates, a consultant firm retained by the Advocate's Office (please see Appendix A for a list of Advisory Council members). Members of the Child and Youth Advocate Office participated in meetings as resources, as did other representatives from provincial departments and the Regional Health Authorities. Through the review process the Council heard from First Nation service providers and Indigenous youth during public consultation sessions and experts in Indigenous mental health. They also conducted a literature review on Indigenous youth suicide and promising factors in this area and gained a more comprehensive understanding of the many jurisdictions, structures and parties which play a role in Indigenous youth mental health. Health Directors from some communities were also able to begin the work of providing a statistical picture of the impacts of youth suicide in their communities.

The Advisory Council's report, which is set out in full as an appendix to this report, gives a preliminary snapshot of the added jurisdictional and cultural challenges and opportunities involved in providing mental health services for Indigenous people. The report is divided into three sections giving: i) an overview of the problem of youth mental health service provision and youth suicide in Indigenous communities and of the work done to date; ii) an outline of the importance of supporting language and culture as a basis for intervention including models for intervention; and concludes with suggested paths for development in improving services in the months and years ahead. The report contains eight high level recommendations for improving mental health service delivery and outcomes for Indigenous youth in New Brunswick, as set out immediately below. The full report in the appendix also includes a companion statistical report in relation to demographics, mental health related statistics and the social determinants of health for indigenous youth populations in New Brunswick.

Hundreds of unmarked and undocumented graves of Indigenous children are terrible evidence of the treatment of Indigenous children and youth in this country. Our Review has found ample evidence of the intergenerational impacts of Canada's past genocidal policies here in New Brunswick First Nations communities as well. Reconciliation of past and current injustices and inequalities requires everyone in this province to not only be aware of the situations of Indigenous peoples but support meaningful solutions. While mental health supports for Indigenous children is constitutionally a 'federal responsibility', New Brunswick has both moral and legal obligations to support Indigenous children living in New Brunswick, both within and outside First Nations communities.

The statistical portrait of social determinants of health in New Brunswick First Nations communities in 2021 set out in the First Nations Advisory Council report below is not encouraging. While unemployment rates for Indigenous persons in Atlantic Canada have dropped significantly to narrow the gap with their non-indigenous peers, from a nearly 10% spread in 2016 (19.0% unemployment for aboriginal persons over 15 compared to 9.9% for their non-indigenous peers) to a 2.8% spread in 2020 (13.4% unemployed compared to 10.6%), food insecurity in Indigenous households remains significantly higher. Moreover, while the educational achievement data from the 2016 census for New Brunswick also points to encouraging progress in closing the educational divide between Indigenous and non-indigenous populations, university graduation rates at undergraduate and post-graduate levels remain roughly twice as high for non-indigenous persons as for First Nations members. After-tax average incomes also remain about 25% lower for Indigenous persons and lower still for Indigenous persons on-reserve, as compared to their non-indigenous peers. Concomitantly, poverty rates are higher among Indigenous households than their non-indigenous peers and children 0 to 17 are much more likely to be growing up in low-income households (37% of Indigenous children compared to 21.7% for their peers).

This data shows some progress on social determinants of health over time but the gaps remain significant. In this context the outcomes in terms of child well-being in 2021 are no more encouraging than ten years ago in the Advocate *State of the Child* report for 2009 or its Hand in Hand report of 2010. The health inequities faced by First Nations children and young people in New Brunswick compared to their non-indigenous peers are not only enduring but actually glaring. The data points to rates of bullying and reported sexual violations that are almost 30% higher than their non-indigenous peers. Indigenous youth report feeling sad, hopeless, depressed or anxious at rates that are 20% to 25% higher than their non-indigenous peers.

In terms of family structure 76% of non-indigenous children and youth in New Brunswick live in two parent households, compared to 23% in single parent families and 1% in alternative care. For Indigenous children the rates in New Brunswick are 55%, 42% and 4% respectively. Indigenous youth report smoking on a daily basis twice as frequently as their non-indigenous peers (9.3% compared to 4.4% of youth surveyed) and consuming cannabis almost three times as frequently (7.8% compared to 2.7% of youth). Indigenous youth were also much more likely to report low life satisfaction than their non-indigenous peers. Their rate of suicide, while not available provincially, was for youth 15 to 24 years of age in Canada fifteen times higher for Indigenous women and girls living on reserve as for their non-indigenous peers (52.9 deaths per 100,000 person years at risk compared to 3.3 deaths) and 6 to 7 times higher for boys and young men in the same age bracket (78.8 deaths per 100,000 person years at risk compared to 11.9 deaths).

Beyond this statistical analysis we also heard, through our community consultation and listening tour, about the devastating toll of premature death and suicide in First Nations communities. Only a few communities were able to share actual data, but all were able to confirm anecdotally the weight of the losses caused by these important health inequities across communities. Elsipogtog's data analysis is set out in the appendix below and tells the story of a community of roughly 3000 souls that in the span of 30 years has lost 159 members to tragic and traumatic deaths. Fifty-four of those deaths were due to suicide, an average of almost two suicides per year in this very small community. Two thirds of those suicide deaths were among youth under 30 years of age. In the face of these devastating findings, we confirm the pressing need for not only further study, but for an urgent and concerted effort in New Brunswick, by all levels of government, for a strengthened commitment to Reconciliation. There can be no equality, no Equal Opportunity in New Brunswick, without equal opportunities for Indigenous children.

We particularly welcome, as the New Brunswick Child and Youth Advocate, in Canada's only officially bilingual province, the claims and demands by our Wabanaki brothers and sisters for linguistic equality. New Brunswickers have defined themselves, for many years, across generations, based upon our commitment to minority language rights. We understand better than most the crucial importance of linguistic security as a social determinant of health, identity and human dignity. We understand also how culturally based health care is of critical importance in achieving equity in health outcomes. The Province of New Brunswick also has an imperative role to play in preserving Wabanaki languages. These are the very languages of first contact between eastern and western hemispheres, between Turtle Island and the Old World. New Brunswickers cannot wait on the federal government for language preservation and reclamation programs that may never come in time. The UNESCO Atlas of the World's Languages in Danger still lists the Mi'gmaq language as vulnerable and the Wolastoqiyik language as severely endangered.[30] In 2018 the Child and Youth Advocate made this recommendation:

> Government should act immediately in consultation with First Nations governments and other Indigenous stakeholders to preserve and promote Indigenous languages native to our Province. An immediate plan should be in place within six months. A long-term plan should be in place within one year. Mi'gmaq and Wolastoqiyik should be the language of instruction in schools for First Nations students. These should also be available as optional-language instruction for non-Indigenous students. Mi'gmaq and Wolastoqiyik language status should be protected in New Brunswick legislation.[31]

Three years later, the First Nations Advisory Council to this review is in the position of having to make a similar recommendation again, its first of eight recommendations listed in their report and endorsed below by the Advocate. These suggestions for reform were also supported compellingly in the brief submitted by Indigenous Women of the Wabanaki Territories (IWWT):

> Often our communities are facing immense challenges due to loss of language and diminished culture; lateral violence and cognitive imperialism; poverty and homelessness; substance abuse and gender based violence; paternalistic colonial education and systemic racism; and barriers to labour force training and employment. At times, these challenges reduce the abilities of our social structures to support our youth, who can feel hopelessness, disconnection, and despair when reflecting on their past, present and future. Youth suicide occurs in our communities at an alarming rate, reverberating through every family, mind and body. [...] The fact that we are still here and growing is a testament to Wabanaki resiliency and perseverance. We acknowledge the immense value Wabanaki intervention and care services such as Wampum CISM and community health, child and family, suicide prevention and addictions services play in our support networks.

What the First Nations Advisory Council and community stakeholders such as IWWT are also essentially asking for is a new relationship between First Nations leadership and the provincial government, one in which the original cultures of this land are respected, and one based not only on consultation but collaboration. The Advocate fully supports these calls to action.

Mental Health Challenges Across Government Services in Health, Education, Child Welfare and Youth Justice and Policing

Health

Our review has found that while much work has been done in New Brunswick in recent years to address the need for multidisciplinary approaches to youth mental health service delivery, the strategic thinking and planning of youth mental health service transformations remains primarily led by the formal health system and its leaders. The system's ability to understand the patient's needs from a life-span and whole-child approach, studying the impacts of mental illness on other youth domains including education, work, family relationships and social and peer interactions is therefore compromised. Families, communities and young people want to have their say in systems reforms and in program delivery. Other child and youth serving departments need to engage in this conversation as well.

The Advocate is encouraged by Minister of Health, Dorothy Sheppard's leadership in this regard through the establishment of a ministerial interdepartmental committee on Addictions and Mental Health. The Network of excellence conversations informing a new model for Stepped Care and the active engagement of community stakeholders such as the Fédération des jeunes francophones du NB (FJFNB) and Partners for Youth in helping to define practice standards for integrated services are also encouraging steps in the right direction.

We find however that for child and youth health services to be adequately addressed, they need their own lens adapted to children and young people's developmental stage and particular needs. The challenge in health, in this regard is no different from the challenge in Social Development or in Justice and Public Safety. Developing dedicated approaches to service delivery to children and young people requires service providers to move away from one size fits all strategies as it creates risks in relation to the transitioning of clients from child and youth teams to adult services. It is, however, the best way to ensure best interests interventions for children and young people, to ensure that their voices are given due weight and consideration in decision-making, to ensure that they are provided equal access to services without discrimination, based upon their age or any other characteristic and to ensure that the interventions they receive are assiduously directed towards their life, survival and optimum development.

We find that combining this horizontal management approach to child and youth mental health services, allowing for improved community, child and family participation in decision-making based upon child rights approaches along with a thorough reform of formal systems of care centred around stepped care interventions and continued service integration efforts will result in significantly improved care and eventually better outcomes and quality of life for young persons and future generations of New Brunswickers. The Department of Health and GNB partners have invested significant effort towards this goal, through consultation with family and youth stakeholders, conversations within the Network of Excellence and the development of a family engagement indicator within the proposed ISD Change indicators, but all of this work needs to be more broadly applied in order to yield results.

Another significant barrier to accessing mental health services that was expressed throughout the Review is the lack of mental health professionals and experts which inescapably contributes to long wait times. The staff shortages also contribute to more challenging work conditions, staff turnover, burnout and compassion fatigue. The NB Nurses union reported earlier this year that in 2020 NB nurses had logged almost 200 000 hours of overtime.[32] New Brunswick is struggling to meet its goals for recruitment and retention of health care professionals. Beyond the chronic lack of nurses, and particularly psychiatric nurses, another glaring hole in the current system is the province's struggle to fill psychologist positions within both the anglophone and francophone education systems.

During an interview conducted for the purpose of the Review, a Learning Specialist with Education and Early Childhood Development confirmed that currently less than 50% of psychologists' positions are filled within the anglophone sector, with that number being only slightly over 50% for the francophone sector. These numbers are troubling as school-based child and youth teams provide a primary channel for children and youth to access mental health resources. These vacancies reduce the avenues for access to mental health supports and information within schools which diminishes the opportunities for children and youth to access these important services. School parent advisory committees also wrote to us expressing their concern over this lack of specialized resources at the school level and the need to imbed mental health services in schools. We will return to this gap below under the Education heading. Psychologists are also in high demand to fill existing vacancies in both provincial health authorities. As of this year provincial mental health services are operating with nearly a 25% vacancy rate among the number of approved psychiatry positions, with only 79 of 104 positions filled.

Our literature review also showed a consistent endorsement of continuous training for professionals, including training on cultural competency and postvention. In New Brunswick, the "Inter-Departmental Addiction and Mental Health Action Plan" and the 21 recommendations recently released both acknowledge the importance of training professionals in the field of mental health and suicide prevention.[33] Training for emergency department workers is prioritized in light of the recent death by suicide of Lexi Daken, but the goal to "[d]evelop and distribute crisis care educational resource material to individuals and community service providers" is also included.[34]

The files disclosed by various public agencies demonstrated that training sessions have been implemented for various professionals on several mental health topics. Training qualifications or desired qualifications for professionals such as psychologists, mobile crisis teams, and Emergency Department nurses are also outlined by Horizon or professional bodies. However, documents disclosed confirmed a need for continuous training, specialized training such as in play therapy and complex cases for ISD teams, more interdepartmental training, and training on cultural competency, training for services to vulnerable populations including LGBTQIS+ youth and youth with particular conditions, including youth with FASD or youth with eating disorders. The need for improved training services was also clearly underscored in both the youth and adult survey results. It is important that cultural safety and acceptability are achieved as well as access to quality care in order to better treat children and youth who present with mental health issues.

Education

Public awareness of mental wellness and mental health services is highly important to ensure that children's right to health is being met. The school curriculum updates which include mental wellness and suicide prevention modules are useful in providing children with exposure to these topics. Research suggests that broad-based programs promoting mental health that reach youth at home, in school or post-secondary institutions supplemented by prevention programs that target at-risk youth have been proven to be effective.[35] The more mental health and wellness is discussed in school and at home, the more the topic will become normalized and youths will feel more comfortable reaching out for help.

Having psychologists and increased numbers of licensed therapeutic counsellors and behavior intervention workers in schools is critical to meeting the demands and needs that students present in school environments today. As mentioned above, the challenge in recruiting and retaining psychologists is particularly burdensome and more so in anglophone districts. Over the years these positions have become increasingly more difficult to fill with higher wages being available in neighboring provinces as well as new licensing requirements from the College of Psychologists of New Brunswick. In order to be a licensed psychologist in New Brunswick, a doctoral degree in psychology (PhD or PsyD) is required whereas in previous years a Master's degree was sufficient. This trend in professionalization of practice is a happening across North America and New Brunswick is now one of five provinces which have a PhD requirement for licensing purposes.

New Brunswick does have a recruitment and retention strategy in place or in development for many health care professionals. For instance, there are incentive programs in place for physicians and specialists which offer monetary incentives for establishing a practice or working within New Brunswick.[36]

These incentive programs cover all types of medicine and do apply to physicians looking to work in the mental health field. Nonetheless, a pressing question remains, is this sufficient to recruit and retain mental health professionals in our province?

In New Brunswick and elsewhere in Canada, evidence suggests that the current supply of psychologists is not enough to ensure timely access to quality psychological and mental health services in view of the growing demand and other complex driving factors.[37]

The evidence clearly indicates that the status quo is no longer acceptable. Progressive and innovative public policies are needed to influence the crucial changes required to address many of the barriers impeding timely access to quality mental health care.

New Brunswick has identified retention and recruitment of professionals as a pressing issue and in December of 2020 the New Brunswick Department of Health released a Psychologists' Resource Strategy and a Psychologists' Resource Strategy Steering Committee was established in March 2019 with a mandate to develop a five-year psychologists' resource strategy for New Brunswick. We hope that this new commitment to recruitment and retention of psychologists will prove fruitful as the status quo is damaging and is failing to provide children and youth the opportunity to access important and potentially life altering mental health resources. Filling the vacancies for psychologists in schools would require by itself another $6 or $7 million in spending. Finding another 24 psychiatrists would add additional significant costs. The cost of not providing adequate health services is to see more children and youth die unnecessarily.

Recent changes in legislation through Bill 35 this spring will allow teachers with masters of counselling degrees to be trained to carry out some testing previously done by psychologists. While the Bill was met with considerable resistance when introduced[38], the Advocate welcomes the initiative as one further tool to attract and apply more resources to a chronically short-staffed field of practice. Hopefully, these legislative changes will free up more psychology time for other much needed therapeutic and diagnostic work. On the whole however, we find that much more will need to be done to meet the demand for access to mental health supports and guidance in school-based settings, particularly in the immediate post-pandemic phase. Retention and recruitment strategies for licensed counselling therapists and behaviour intervention workers should also be developed. Most importantly, the vacancies in relation to psychologists need to be urgently addressed.

Many of the files disclosed during the Review by Education & Early Child Development from 2009-2021 mention updates to the mental health curriculum in schools, however survey responses suggest that more practical guidance needs to be provided or more resources need to be made easily accessible and known to children, parents, and the community through other sources. Our survey of New Brunswickers found that only 22% of adults and 39% of youth felt they had tools and/or resources to provide support through the NB Mental Health System to a youth in need. Parents are encouraged by the early interventions they are seeing in elementary schools, through the emphasis on mindfulness practices and a curriculum that supports overall wellbeing.

Child Welfare

Through the literature review conducted for the purpose of this study, it was found that New Brunswick's child welfare system is struggling to offer youth adequate support services to provide a stable family environment. A stable family environment is key to enhancing mental wellness and decreasing suicide risk and self-harming behaviors. The Canadian Child Welfare Research Portal defines "child welfare" as follows:

> "Child welfare" is a term used to describe a set of government and private services designed to protect children and encourage family stability. The main aim of these services is to safeguard children from abuse and neglect. Child welfare agencies will typically investigate allegations of abuse and neglect (these activities are called "child protection services"), supervise foster care and arrange adoptions. They also offer services aimed to support families so that they can stay intact and raise children successfully.[39]

The term "child welfare system" is defined more broadly in this report to "include all aspects of prevention of child abuse, neglect and preventable harm, actions taken to address abuse, neglect and harm after they occur, and services to provide rehabilitation, stability, and permanent caring connections."[40]

The child welfare system is intended to aid and protect children, however entering the system is often itself a source of conflict and trauma for children and youth. Our review has found that more attention needs to be given to the traumatic impacts for children of child protection interventions and to treating the past trauma that may have led to a young person's placement in care. Removing a child and placing them in a stable environment in the hopes that they will recover and move on is no longer good enough. Integrated Service Delivery (ISD) interventions should be accessed and initiated regularly for every child placed in care so that health system and educational system interventions can be mobilized to support the young person through this difficult transition. In the past, the cone of silence around child protection matters has been so strong that even classroom teachers were rarely informed of a child's placement in care. In this regard, however, the Advocate finds that the practice while well intended is not justified, nor is it founded upon a child's best interests. A prudent and responsible parent should inform a child's teacher about an important life-change such as this so that the child's behavior can be properly monitored, and their learning environment and outcomes appropriately adjusted.

The recommendations in this report reinforce the Advocate's recommendations for child welfare reform in Behind Closed Doors from 2018, and in its upcoming report *We Are What We Live*, to be released next month.

Youth Justice

Many youths within the criminal justice system experience mental health concerns. However, statistics regarding the prevalence of mental illness specifically for youth in the criminal justice system in Canada are not readily available. This has been recognized as a research gap which needs to be addressed[41]. One paper, based on American studies, states that "[a]pproximately 65 percent to 70 percent of youth in the juvenile justice system have a diagnosable mental health disorder"[42] while in another study over 90% of youth entering a state's juvenile justice system met the criteria for a diagnosis of a major depressive episode, a manic episode, panic attacks, post traumatic stress disorder, conduct disorder, or substance dependence.[43]

There is a need for more mental health services to prevent youth from becoming involved with the criminal justice system as well as a need to divert youth from the criminal justice system to appropriate mental health services.

Our Review has found that, as with all youth, diversion away from traditional prosecution and trial approaches should occur wherever appropriate. Extra judicial measures should be considered first, and extra judicial sanctions used where extra judicial measures are not sufficient. It is essential that the Province begin to shift their focus to the root cause of the offence rather than punishing the youth offender. The *responsivity principle* of the New Brunswick Youth Diversion Model is meant to ensure that interventions correspond to the individual youth's needs. One of the factors considered under this principle is their mental health status. It is vital that every single youth involved within the justice system have their mental health needs met. The development of and fidelity to a mental health assessment tool for the criminal justice system is essential in reaching this goal.

Section 39(5) of the *Youth Criminal Justice Act* highlights the focus on diversion methods by stating that custody is not an appropriate substitute for accessing mental health services. All alternatives must be considered before a youth is sentenced to custody. A youth's mental health can also be negatively impacted by custody[44]. While the Advocate's Office recognizes the immense progress that has been made by the Courts and Justice and Public Safety in recent years in reducing the overall rate of youth incarceration in New Brunswick, bringing us in line with the relatively low youth crime rate and incarceration levels seen elsewhere in Atlantic Canada, we remain concerned that most of the youth at the New Brunswick Youth Centre (NBYC) continue to have complex needs and that a number of incarcerated youth might benefit from more specialized interventions in non-custodial settings and in health care settings rather than correctional ones. More diversion methods need to be implemented to address the mental health needs of youth.

FEEDBACK FROM YOUTH, FAMILIES AND COMMUNITIES

One of the long-standing issues in youth mental health service provision in New Brunswick is the constant demand for more and better child, youth, family and community engagement in decision-making, policy-making and service monitoring. We continued to hear from New Brunswickers on this topic in clear terms through our online survey, our public consultation tour, our key informant interviews and the submitted briefs. Our own literature review confirms the need for this policy orientation. This is true as a matter of principle, in accordance with the child's right of participation. But it is especially true in child and youth mental health service provision in relation to families and carers because of the critical role they play in recovery.[45]

Traditionally, policy focus is on formal service provision as primary determinants for mental health outcomes, with the assumption that we get better results with better services. This can limit successful outcomes if it is not balanced with other supporting options such as a thriving informal support system. Formal mental health services are important, but we can go further including and supporting strong informal supports.

Informal support systems include family, friends, acquaintances and the involvement and contributions of youth with lived experiences. Informal supports in community also include NGOs, religious organizations, service organizations, sports clubs, music groups, art groups, peer support groups, chess clubs, parent education and support around specific mental health issues (for example, support groups for parents of children and youth with eating disorders or FASD family support groups). Important aspects of this knowledge base are either ignored or underutilized by many groups including professionals, policy makers and the public.

Informal support organizations previously mentioned can provide the opportunity for meaningful involvement in community life that is outside the realm of mental health or professional services. Families are the largest group of caregivers, often providing financial, emotional and social support although their role often goes unrecognized. In addition to providing support to their loved one, they can also provide support to one another and to other families as well. Families contribute experiential knowledge of the impact of poor mental health on their loved one and what it means in a larger life context. Youth with experiential knowledge can inform and advise what works for them and what doesn't. They can provide valuable suggestions on improving interventions and services that are helpful.

When formal and informal systems work together with mutually shared commitments and obligations to better support vulnerable children and youth we tend to get better outcomes when addressing mental health issues.

Youth Suicide Prevention and Mental Health Services Survey

The Youth Suicide Prevention and Mental Health Services Survey was open to all New Brunswickers and included 28 questions to help inform the Office of the Child & Youth Advocate about recommendations on mental health access for children and youth throughout the province. 3368 adults and 736 youth completed the survey. Some of the summarized findings are reported below.

Survey responses demonstrate that parents in New Brunswick are looking for resources and are committed to being involved in their child or youth's mental health care. Adults commented that they wanted to see more counselling or psychotherapy services or clinics that are inclusive to families (parents and siblings). Adults are also seeking education and training on mental health to better support their children, as well as parenting support groups. Only 22.4% of adults and 38.7% of youth who completed the survey felt they had the tools and/or resources to provide support through the mental health system in New Brunswick to a youth.

As seen in the survey many people felt that proper services were not available and changes needed to be made to the mental health system in New Brunswick. In response to the survey question "What do you think of the mental health support available to youth in NB? (Please rate with 10 being high and 1 being low)", 65.6% of adult respondents rated the quantity a 1, 2 or 3 and only 3.3% total gave a score of 8 or above. With respect to the quality of services 56.4% of the adult respondents gave a score of 1, 2, or 3 and only 6.2% gave a score of 8, 9, or 10.

Youth expressed a need for suicidal thoughts to be taken more seriously when expressed to professionals, including guidance counsellors and hospital staff. Youth also expressed that services need to be available more promptly for youth who are experiencing suicidal ideation.

Based on the comments from the survey it appears that training on mental health provided to various professionals who work with children and youth varies greatly. Many of the survey respondents listed the numerous training courses they had received, and others expressed their concern with the lack of training provided by their employers.

Many youth who completed the survey expressed their concern regarding the treatment they received from professionals when seeking mental health assistance or guidance. Survey responses also indicated a need for further training regarding mental health for police, legal professionals and others who interact with youth in the criminal justice system. Requests were made for social workers or other mental health workers to be available on evenings and weekends, including the mobile crisis team. Youth also requested more psychologists or counsellors in schools but emphasized that these staff need to have more mental health training.

Based on the survey results, youths seemed more comfortable accessing mental health services in person rather than virtually. The pandemic has undoubtedly altered the delivery of therapy, counselling and mental health services. Hopefully, with restrictions easing and the province moving to the Green Phase of the recovery plan, in-person services can resume while maintaining the ease of access that online services have opened up for many others.

A majority of youth surveyed and who responded that they had accessed mental health services, indicated that they had done so because they were feeling worried or stressed (81.2%). However, notably 64% of the youth who completed the survey were also accessing mental health services due to suicidal thoughts. As mentioned above, mental health, suicidal thoughts and attempts are often interrelated.

Youths expressed that long wait times to access mental health services was a major barrier within our healthcare system. Youths also stated that there is a lack of specialized support for the LGBTQIS+ community and individuals with eating disorders.

Many youths expressed that mental health remained heavily stigmatized and was not a topic that was discussed enough in school and among families. This issue made it difficult to confide in their parents, teachers or professionals about their struggles because they feared they would be shamed, ostracized, or would simply not receive adequate help or treatment. Many youths reported choosing not to access services as they were concerned that their disclosures would be shared with others, primarily their parents. Additionally, many youths did not know about the available mental health resources or helplines. Transportation to appointments was also listed as a barrier to service access by many youths.

Many youths and adults identified continued care and access to continued care as an issue, expressing that the cost of private counselling is a major hurdle and that their struggles with mental health often outlived their time getting treatment.

Public consultation

During the months of May and June, a virtual public consultation tour with the Advocate took place within 10 different regions across New Brunswick. The purpose of these sessions was to hear directly from residents across the province about suicide prevention and mental health services within their respective communities. Participants in each session included service providers from both the public and private sectors, parents, youth and other community members. There was a high level of engagement with approximately 260 citizens registered for the consultations.

Numerous themes were listed at each session to guide the discussion and participants were at liberty to discuss the subject matters relating to mental health that were of relevance to them. Through the sessions our office was able to gather qualitative data specific to these communities concerning barriers and systemic gaps in services and service delivery, as well as listen to what they were proposing as solution-based ideas and recommendations that could enhance mental health services for youth. All feedback received during the tour was taken into consideration for the drafting of our final recommendations. Discussions were rich and community members genuinely wanted all children and youth to obtain timely, adequate and meaningful services during mental health crises.

The data and feedback collected at the public consultation tour was categorized under the following themes: Access to quality care, Investing in professional and quality care, Integrated Service Delivery team, Family supports, Peer supports, Community supports, Accessibility and cultural safety of mental health services, Quality control and service standards, Public consultation and public education, Healthcare services (Emergency Room response/ mobile crisis), Funding, Early childhood interventions, Consent, Confidentiality, Aging out of youth based mental health services, Opportunities for teachers and parents, and Other.

Recommendations suggested by participants under each theme were recorded and forwarded to the Review team for consideration in developing the final recommendations from the Review.

Many common themes emerged across all 10 regions. Long waitlists to access mental health services, long wait-times at the Emergency Department, transportation and the lack of mental health professionals were expressed as barriers in every region. The stigma surrounding mental illness was also voiced as a reason why youths did not seek help when struggling. Children and parents felt as though they were not resourced with the appropriate tools or knowledge to help their friends or children during a mental health crisis. The need for 24/7 mental health services was recommended by every community. The transition to adulthood was an important part of the consultation discussion. Many youths find it difficult knowing that the service providers that supported them during their youth will not be able to offer their support as they leave the public school system.

Although many common topics were discussed, the online sessions were also extremely helpful in getting a sense of local contexts. For instance, in Edmundston, the plea for early childhood educators to start mental wellness interventions in early years and their frustrations and concerns regarding the Maillon program's budget being cut was strongly put forward. In Upper River Valley and Charlotte County, we were moved by the enduring grief of parents who had lost children to suicide. In Moncton we got a different perspective from university counselling teams and the issues regarding access to services in post-secondary settings was highlighted. The bigger cities such as Fredericton, Moncton and Saint John discussed their experience at the Emergency Department and the long wait-times. River Valley discussed the need for online services which would increase accessibility and privacy of mental health services. In the Acadian Peninsula region, participants expressed that many youths have benefited from community-based services offered by organisations such as Access Open Minds, le Centre de Bénévolat, the Canadian Association for Mental Health and others.

The Virtual Public Consultation Tour was an invaluable source for the drafting of our recommendations and for developing a better understanding of common barriers to mental health services but also region specific concerns, gaps, and needs. The office would like to express their deepest gratitude to all participants for their involvement and contribution to this Review.

FINAL RECOMMENDATIONS

A New Governance Model for Services to Children and Youth

Consistent with our recommendation in the 2008 *Connecting the Dots* Report, the Advocate is again recommending the establishment of a Minister responsible for children and youth. This Minister should be supported by a Secretariat for children and youth. Disabled persons, women, Indigenous people and francophone minorities all have government bodies working around the clock for their welfare. This review of youth mental health and Integrated Service Delivery has convinced us that it is well past the time for children and young people to have their own champion at the Cabinet table and within the executive Branch of Government. This Secretariat with its own Deputy Head could lead the Integrated Service Delivery work across all participating departments. They could take the lead on government reporting and monitoring of child rights implementation and child rights impact assessments. They would be responsible to ensure the alignment of all services to children and youth across government through an Interdepartmental Committee on Children and Youth, where the Advocate, children and young people themselves, carers and families and other representatives from civil society could also be invited to join in open sessions. Alignment of services in this context implies that authority for program delivery and operations continues to lie with line departments, but that the Secretariat, through its Minister responsible for Children and Youth may be called upon to break a logjam or dispute over which department or agency must pay to meet a given child's needs. This Interdepartmental Committee on Children and Youth would advise and be supported by the Secretariat and should be composed of Deputies from Health, Social Development, Education and Early Childhood Development, Justice and Public Safety, Post-Secondary Education Training and Labour, Aboriginal Affairs, Culture and Tourism, Women's Equality Branch, Aboriginal Affairs and the Premier's Council on the Status of Disabled Persons. Deputy involvement is important to ensure that through their leadership to their Departments mandates are met for children and youth, barriers to services and supports are removed, collaboration with partner Departments occurs and innovative ideas are promoted.

As in *Connecting the Dots*, and upon the advice of our Advisory Board, we are strategically placing this recommendation as the very first of our recommendations as we are convinced that this commitment to a central coordinating mechanism across government for all services to children and youth is what is most urgently needed to guarantee the success of all future reforms. Indeed, we are convinced after hearing from many government officials past and present, that many of our failures to make better, swifter progress on these fronts can be attributed to the lack of coordination and central decision-making, despite valiant attempts at service coordination for instance through ISD or the network of excellence.

We have heard and welcome the word of caution sounded by officials who worry about a fragmentation of approaches between youth and adults in mental health services and the challenges in transitions in care that this may pose. We welcome also the leadership provided by the Minister of Health as chair of the Ministerial Committee on Addictions and Mental Health and we believe that that table must continue to govern the Province's overall Mental Health and Addictions Strategy. We would welcome the opportunity for on-going representation of the Advocate's office at that table.

Nevertheless, we respectfully submit that taking a patient centric approach to the work at hand requires all of us as duty bearers to children to consider their health care needs and rights in the context of all their other rights and interests. Indeed, we must adhere to a governance model for services to children and young people that allows us to adopt rights-based approaches rather than only needs based approaches. The Committee's mandate should build from the mandate of the Interdepartmental committee on Children and Youth, established by ECO in 2015 for monitoring of the Strategy for the Prevention of Harm to children and youth, ongoing training and monitoring of the Province's child rights impact assessment process and coordination of child and youth services across government. Other priorities and mandates of the committee would emerge from the implementation of the recommendations in this report. At a minimum, we must, based on the recommendations from this Review, revisit the *2021-25 Mental Health and Addictions Plan* and develop a Child and Youth Mental Health and Suicide Prevention Strategy that can serve as a focused and adapted subset of both the provincial mental health and addictions plan and a new comprehensive provincial child and youth strategy to enforce child and youth rights.

Recommendation I

It is recommended that the Province of New Brunswick appoint a Minister responsible for Children and Youth, that the mandate of this minister include youth up to the age of 25 and that the Minister be supported by a Secretariat for Children and Youth lead by its own Deputy Head. It is recommended that the Secretariat be responsible for the coordination of Integrated Service Delivery as well as the alignment of services to children and youth across government through the development of a Standing Interdepartmental Committee on Children and Youth. This committee should be responsible with the Secretariat for the training and implementation of Child Rights Impact Assessment and the development of a provincial Action Plan for Child and Youth Mental Health and Suicide Prevention.

Improving Community-Based Interventions and Services

The second broad area of recommendations stemming from our review is around the call for improved emphasis in community-based interventions and care in youth suicide prevention and mental health services. In a sense we believe that this will be a welcome recommendation by government since Integrated Service Delivery, the Stepped Care Model, Social Pediatrics in Community and so many other priorities of government in this sector are already founded upon and committed towards this vision. Nonetheless, our review has confirmed that while the commitment in principle to community-based care is real, our failure to meaningfully engage family, youth and communities in the transitions and service delivery we envision is also very real. Community-based partners have a lot to deliver in this space. They want in. And young people, their carers and family want more service provision driven at the community level as well.

A new commitment to community-based interventions and services will require new funding to support these investments in health care. The Province must strategically direct renewed federal transfers particularly in the post COVID recovery era towards these community-based interventions and services. Some funding could also be diverted from hospital-based care towards community services.

The Province should invest in dedicated health research initiatives to support the evaluation of new community-based interventions and supports, and they should leverage all of these investments in community with the philanthropic and business sectors based upon the strong business impacts of improved wellbeing across the labour force, particularly among young workers.

Beyond improved funding, research and evaluation, improved community-based interventions and services will require a strengthened commitment to child and youth participation in policy-development and service implementation and review, careful attention to the transportation needs of patients in rural and urban settings, expanded coordination of health information sharing protocols and practices between health information custodians and community partners, as well as intensive cross-training investments to support trauma informed approaches, child-rights based approaches, cultural safety, mental health literacy and suicide intervention training in multi-disciplinary settings inclusive of family, youth and community. Significantly, it will also require additional supports for public awareness, education, navigational supports, peer supports (to youth and family members) and network supports to keep the many partners in this process of transformation change engaged and alert to best practices and service innovation. It is one of the strengths of community-based intervention to be able to innovate and adapt recommended practices and interventions to local needs. This is how best practices emerge, but only if network supports are in place.

Recommendation II

It is recommended that the Province's proposed Action Plan for Child and Youth Mental Health and Suicide Prevention should ensure measurable progress over the next five years in reducing inappropriate hospital admissions for youth mental health disorders and invest strategically in upstream prevention and early intervention community-based programs and supports in keeping with the Stepped Model of Care outlined in the Interdepartmental Addictions and Mental Health Action Plan. The new investments by the Province at the community level should be used to leverage local business sector and philanthropic sector contributions so as to maintain community-based ownership of the interventions. These interventions should be provincially funded based upon the best available evidence, properly evaluated, and their impacts supported by expert knowledge translation efforts.

It is further recommended that the Community engagement aspect of the Action Plan should be managed by community through the efforts of a lead non-profit sector agency acting as the convenor of these conversations, along the lines of the United Way Manitoba initiative supported by the Graham Boeckh Foundation. This backbone organization will ensure that the Action Plan is developed with the active participation of young people with lived experience of mental health services, their peers, family members and community allies. The organization will ensure that these members meet regularly through supported local and provincial forums as well as with the Interdepartmental Committee on Children and Youth to monitor the progress and implementation of the Action Plan.

For further specificity, the Advocate recommends that targeted community-based interventions be considered for funding including:

- ACCESS Open Minds site expansions
- Atlantic Wellness Center type supports
- The Link program chapter development
- Social Pediatrics in Community service points
- Indigenous land-based two eyed seeing interventions
- Child Advocacy Centres for child victims of abuse
- Sistema orchestral programs, local CMHA chapters, Boys and Girls Clubs, Big Brother, Big Sister chapters, local YMCAs, targeting youth mental health fitness and suicide intervention supports

Moreover, the Advocate also suggests that key components of the Action Plan recommended above should include training and professional development actions, public education and awareness actions, evidence-based prevention and promotion programs including school-based educational programs, peer based supports for youth and families, navigational supports, child and youth participation benchmarks, child right to health indicators as well as supports and mechanisms to network conversations amongst all child and youth mental health stakeholders across the Province.

Protecting the right to health and the right to life

The Advocate's mandate is to protect, defend and promote the rights of children and youth. As we have recently stated in our report in relation to child welfare in New Brunswick, it is time for the New Brunswick Legislature to adopt the *UN Convention on the Rights of the Child* (UNCRC) as New Brunswick law. Of course, these rights are guaranteed to children all around the world. As Canada has ratified this convention over 30 years ago these undertakings are binding on Canada and on the Government of New Brunswick. We are accountable for our efforts in the implementation of these rights before the Assembly of the world's nations through the Convention's treaty organ, the Committee on the Rights of the Child. In New Brunswick we have been monitoring the implementation of these rights through the State of the Child Report and Child Rights Indicator Framework. We have also adopted a Child Rights Impact Assessment (CRIA) tool to guide decision-making at the cabinet table. At the same time, because of our Parliamentary tradition and constitutional framework as a dualist federal state, the reception of international law requires domestic incorporation by the legislature for all of these rights to be fully justiciable before our civil courts. Our courts have well established precedent to support the view that all laws must be interpreted in keeping with our international legal obligations. Global human rights treaties like the UNCRC are therefore important references whenever courts are called upon to interpret our *Canadian Charter of Rights and Freedoms* or human rights legislation.

In spite of all this we are quite aware of the serious disconnect between the promise to children, by governments everywhere, including our own, that they will "take all appropriate legislative, administrative, and other measures for the implementation of the[se] rights"[46] (Art. 4), the undertaking in Article 6 to "ensure to the maximum extent possible the survival and development of the child"[47] and the guarantee in article 24 to "recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health"[48] and the findings outlined above in our report. Lexi Daken's right to the highest attainable standard of health and to facilities for the treatment of illness was violated in important ways. Her right to survival and development was clearly not ensured to the maximum extent possible. The same can be said for Mona or Hillary two young Mi'gmaq girls who died too young and to whom we dedicated the *Hand in Hand* Report. Julia-Anna St-Peters an infant who died from chronic neglect and all the other children memorialized in the Advocate's previous reports are waiting for their rights to be taken seriously, for their lives to be treated with dignity.

It is not sufficient, to establish an Advocate's office to say they will speak up for you, they will investigate those rights violations, but then to leave the Advocate's recommendations aside, to fail to provide enforceable remedies for these rights violations, and indeed to fail to acknowledge this rights framework within our own legal system. Children and young people demand better. They demand equal justice. The domestic incorporation of the Convention in our law is a straightforward matter. It requires a single provision in the new Child Welfare Legislation. Many stakeholders that we have heard from, including former government officials and the St Thomas School of social work are making this same recommendation to government. It could be done through amendment to the *Education Act*, or the *Health Act*, or through the *Child, Youth and Senior Advocate Act*. It could be done through stand-alone legislation on the model of the statute recently adopted by the Scottish parliament. Other leading democracies with Westminster style parliaments and traditions are leading the way on this front and New Brunswick should lead the way in Canada in this regard by making ourselves accountable under our own law for the promises we have made before the whole world to our own children.

This legislative step is an important foundational development and a structural indicator of rights enforcement – no doubt the most important one, but it is not sufficient in and of itself. This legislative change simply gives a legal foundation within our own body of law for what we have undertaken to do under international law, and what we are in fact doing to a significant degree through the rest of our provincial legislation as it relates to children. We also need policy and program supports to implement this legislative commitment to children's rights and a provincial strategy to guide their implementation, monitoring and enforcement.

Our efforts to improve child and youth mental health would be an important element, but a component part of the overall plan for child rights enforcement. In that way they can become truly child and youth centric and coordinated with all the other important domains of child and youth well-being, development, and rights. Health professionals can be trained to intervene with child and youth patients in ways which always respect the guiding principles of non-discrimination, best interests based decision-making for life survival and maximum development and respect for child and youth voice and their developing sense of agency and autonomy, as important elements of human dignity.

Health professionals can be trained as well to respect the core attributes of the child's right to enjoy the highest attainable standard of health, keeping in mind the criteria of available, accessible, acceptable and quality care. Health professionals should be trained alongside education, child protection and child justice professionals to learn about the essential attributes of child rights informing service delivery in those sectors as well so that children come to expect that all the adults in their lives are allies as duty-bearers to children ready to give the best of themselves to the next generation.

Recommendation III

It is recommended that the proposed Action Plan for Child and Youth Mental Health and Suicide Prevention be embedded within a Provincial Strategy for Child and Youth Rights and that the service transformations it proposes be inspired by child rights-based approaches. The Action Plan should support significant multi-departmental and community sector cross-training efforts to retool educators, health service providers, child protection, justice and policing officials and their community allies with the knowledge they need to meet their obligations as duty-bearers to child and youth rights-holders and use rights informed approaches aligned with trauma informed care.

It is further recommended that in order to consolidate its principled commitment to child rights enforcement, the proposed Minister for Children and Youth and Executive Council Office take swift legislative action to incorporate the Convention on the Rights of the Child into our domestic law.

Equal access to health and life for Indigenous children and youth

The discrimination and inequality faced over generations by Indigenous Peoples in Canada, and the resulting social and health challenges, are a stain on our nation's claim as a champion of human rights. The country has apologized for residential schools.[49] The federal Human Rights Tribunal has held the government to account for discriminatory funding of First Nations child welfare.[50] The Supreme Court of Canada has repeatedly insisted that Aboriginal rights require reconciliation.[51] Canada has agreed to the moral obligations of the UN Declaration on the Rights of Indigenous Peoples.[52] The Truth and Reconciliation Commission has shown a path forward.[53] Yet inequality persists for Indigenous children and youth and global authorities such as the UN Committee on the Rights of the Child are demanding that Canada do better.[54]

The Child and Youth Advocate has recommended, in its interim report to this current review, that the Province fund an independent review of youth suicide prevention and mental health services for Indigenous children and youth, to be undertaken by First Nations experts with the support of the Advocate's office.[55] This Office would like to follow on from the work undertaken in the Advocate's *Hand in Hand* report,[56] to work on a comprehensive review of Indigenous youth mental health services, but only in collaboration with First Nations, as we recognize the need to adhere to the self-determination of First Nations governments.

The right of Indigenous Peoples to collective self-determination is enshrined in the first article of each of the fundamental post World War II human rights treaties, the *International Covenant on Civil and Political Rights*[57] and the *International Covenant on Economic, Social and Cultural Rights*.[58] It is further enshrined in the UN Declaration on the Rights of Indigenous Peoples.[59] Self-determination of distinct peoples has been found to support healthy environments, whereas a lack of control over self-determination has been found to lead to unhealthy environments.[60] The call for self-determination for Indigenous Peoples in Canada has been made repeatedly by individuals and organizations since before the Royal Commission on Aboriginal Peoples,[61] and after the report from the Truth and Reconciliation Commission.[62] Provincial funding should support a First Nations-directed independent review of mental health services, to better uphold the rights Indigenous children and youth.

The Advocate is indebted to the dedicated, generous, and superb work, within a difficult time frame, of the First Nations Advisory Council appointed to this review. The report they have submitted to the Advocate is the result of many hours of discussions, consultations, research and contemplation over the course of these months. The Advocate trusts that the call for a comprehensive review of Indigenous child and youth mental health services will be agreed to. In the meantime, the First Nations Advisory Council's report provides recommendations that give government much to contemplate and act on.

It is certainly no surprise, but yet heartening, to see a focus of that Committee's report being on culture and language as a foundation for mental wellness. Indigenous children and youth have the right, as enshrined in the UN *Convention on the Rights of the Child*, to the highest attainable standard of health, to enjoy their cultural practices, and to be afforded the ability to use their own language.[63] Indigenous culture faces continued threat to its existence as a result of the legacy of Canada's assimilationist policies, systemic federal underfunding of education services, historical bigotry, the intergenerational trauma of the residential schools system and the sixties scoop (wherein tens of thousands of children are estimated to have been removed from their homes and moved to non-Indigenous families), as well as the longstanding underfunding of Indigenous child welfare services. The province has a pivotal role to play in preserving, promoting and providing increased access to Indigenous culture.

The subsequent recommendations are justified more fully in the First Nations Advisory Council's report and statistical analysis set out in the Appendix below. They address important matters in relation to culturally appropriate mental health services, governance, funding, research and reconciliation as well as educational reforms for suicide prevention and mental health services for First Nations children and youth. At the same time, these steps are only preliminary recommendations based upon a cursory examination by First Nations Advisory Council members themselves.

Beyond the consultation with national experts and with some Directors of Health services in First nations communities, there was no opportunity to engage deeply with elders, band councils, service providers and with youth and families themselves across New Brunswick's 16 First Nation communities. It was strongly felt that given the short timelines for this review and the heavy toll of suicide and youth mental health challenges in many of these communities that a rapid consultation would be too triggering. This was before the first reports of unmarked graves in Kamloops were reported this spring.

The Advocate agreed with the advice offered by First Nations mental health experts and in hindsight we are doubly thankful for the approach taken.

We affirm the recommendation in our Interim report for the continuation of this review process with the guidance of the Advisory Council established and the direction that can be given by Band Chiefs. An extended process of Review is needed in First Nations communities because of the depth of the trauma already occasioned by our colonial past and the complexity of needs present in many First Nations communities today across several domains of child and youth wellbeing. Understanding the proper approach to reform in light of child rights principles, UN Declaration on the Rights of Indigenous Persons (UNDRIP) principles, existing treaty rights and nation to nation Indigenous relationships with various levels of Canadian government will also require more time. Our process this spring was focused upon bringing sectoral leaders from First Nations communities and supporting the voice of First Nations Youth and community members themselves as owners and drivers of the solutions for improved mental health services in their community. At the same time we were only able to begin this process, and we were not able to discuss within the Advisory Council, nor with band leaders, or elders and youth, the many recommendations made for reform through the broader consultation process, both from within and without First Nations themselves. The potential for allyship, in the spirit of reconciliation therefore remains fully untapped and will have to be part of the work ahead.

Nonetheless, the urgency of the situation requires some immediate action, as well as a process for deeper reflection.

Recommendation IV

The New Brunswick Child and Youth Advocate endorses the following recommendations from Indigenous experts and allies:

It is recommended that :

A. The Mi'gmaq, Peskotomuhkati and Wolastoqey languages be formally recognized and supported by provincial legislation which:

i. Recognizes that these languages are the original languages of this territory, that Indigenous language rights are part of the Peace and Friendship Treaties and that these languages are currently endangered;

ii. Recognizes Indigenous languages as fundamental and valued in New Brunswick culture and society;

iii. Actively supports Indigenous language revitalization through funding and programs provided by the provincial government and/or in partnership with the federal government;

iv. Affirms that the reclamation, preservation, revitalization and protection of Mi'gmaq, Peskotomuhkati and Wolastoqey languages are best undertaken by these Indigenous peoples and communities.

SUICIDE PREVENTION, ADDICTIONS, AND MENTAL HEALTH SERVICES

B. Culture as Foundation and a Two-Eyed Seeing approach should be used as the basis for implementing mental wellness, health and addictions services for Indigenous youth. Culturally relevant services and programming should be available for Indigenous youth and families through:

i. Co-development with Indigenous peoples and communities;

ii. Indigenous-led community-based services as part of the continuum of services;

iii. Provincial health and mental health programs and services that meet the mental wellness needs of Indigenous people;

iv. Enhanced collaboration between provincial health services and First Nation communities and Indigenous organizations to ensure that Indigenous youth have a culturally safe and seamless experience when using health and mental health services.

HEALTHCARE SYSTEM

C. The Province of New Brunswick and Indigenous communities and organizations work together to effect changes in healthcare structures and processes, such as service design, policy, human and financial resources, program and service delivery with the longer-term goal of cultural safety and improved mental health outcomes for Indigenous people.

D. The Province of New-Brunswick establish a Tripartite forum and an ongoing process involving Indigenous leaders, Directors and organizations, provincial and federal governments to:

i. Develop a framework for culturally appropriate, competent and safe mental health services for Indigenous people;

ii. Improve access, provision and cultural competency and safety of mental health and wellness services for Indigenous youth;

iii. Include First Nation input and oversight on the Indigenous portion of funding and aspects of the Canada-NB Agreement on Mental Health and Addictions;

iv. Establish site(s) as Indigenous-led healing centre(s), (e.g., Lonewater Farm) and enable success with provincial property tax reform and long-term core funding for programming, staff training support, etc.

v. Provide integration of the provincial ISD teams and the Jordan's Principle staff to better serve the needs of Indigenous children and to create a cohesive jurisdictional approach to ensuring no gaps exist in services to Indigenous children.

FUNDING, PUBLIC AWARENESS/RECONCILIATION, AND RESEARCH

E. The Province of New-Brunswick increase transparency on federal health transfer dollars to New Brunswick and expenditures as these pertain to Indigenous mental health services.

F. The Province of New-Brunswick flow the First Nation portion of funding from the Canada-NB Agreement on Mental Health and Addictions through the Tripartite Forum.

G. The Province of New Brunswick fund a separate review of Indigenous youth mental health services, including a scan on a) jurisdictional gaps in service delivery and integration and b) adequacy of funding and services.

H. The Province of New-Brunswick resent the Indigenous Guidance Team recommendations on the Network of Excellence to Indigenous leadership, First Nation Directors of Health, Child Welfare and Education and Indigenous organizations.

EDUCATION

I. The Province of New-Brunswick institute Wabanaki culturally inclusive education policy and legislation at the early learning, secondary and post-secondary levels that upholds the Provincial Government's Constitutional obligations to Indigenous children to provide quality education and includes First Nations people in New Brunswick as residents of New Brunswick with a right to equitable provision of services that is free of systemic racism throughout their education.

J. The Province of New-Brunswick co-develop success indicators with Indigenous people for Indigenous youth in the education system that measure not only academics, but also the holistic needs of Indigenous youth, including their cultures, languages, access to ceremonial practices and mental wellness.

K. The Province of New-Brunswick re-invest 100% of the New Brunswick-First Nation Education Enhancement Agreement dollars to provide programming and services for Indigenous children.

L. The Province of New-Brunswick reinstate the First Nations Ministerial Advisory Committee that was part of the original Enhancement Agreements but has ceased to exist for the past eight years so that recommendations to the Minister will be heard and acted upon.

JUSTICE & PUBLIC SAFETY

M. Judges and Crown Prosecutors receive training on Indigenous intergenerational trauma and culturally relevant options for Indigenous youth who are in conflict with the law so they can better identify appropriate extrajudicial sanctions and sentencing options for Indigenous youth.

The Future of Integrated Service Delivery

Of all the feedback that we received during the course of our review the most contentious was in relation to Integrated Service Delivery (ISD). As outlined above ISD has shown great promise but has also been the source of great frustration for many youths and parents. Some educational professionals were urging government to go back to the drawing board on this reform. Most experts we met with agreed however that ISD is an important service transformation that is here to stay and needs continuous improvement. We agree.

We heard many, many ideas of how to improve ISD. They range from the staffing of ISD teams and the training to offer them, to the practice standards and indicators of success they should follow, to the priority programs they should offer, the partners they should work with and the suggestions for continuous improvement and quality assurance within ISD service delivery. The overwhelming sense we have from New Brunswickers and experts in this field is that ISD is making a difference and it critically needs more resources, greater support from the top echelons of government and a new plan to do even better in partnership with community allies.

One of the challenges we have noted already is the unfortunate exodus of leadership associated with this programme, relatively en masse just before the pandemic hit. In our Interim report we identified the critical gap in failing to implement the ISD fidelity and practice standards initially requested in 2017 from Dr. Bill Morrison. We are pleased to note that that work is once again well in hand. Nonetheless, New Brunswickers should recognize that ISD is a very large undertaking, the proposed service transformation was only rolled out provincially three years ago in 2018 and much training and careful monitoring and evaluation will be required to help achieve ISD's service transformation goals. Local child and youth teams are still learning their own processes, challenges and abilities. Greater coordination is needed to ensure quality outcomes across all regions and the frontlines of all service departments, in health, education, social development and justice also need to be better trained in relation to this system change and its impact. This massive training effort needs to be planned effectively in coordination with training needs related to the Stepped Care Model, Child Rights Based Approaches and Trauma Informed Care.

Keeping in mind these considerations and the findings outlined in our report above the Advocate formulates the following recommendation to government in relation to Integrated Service Delivery.

Recommendation V

It is recommended that the Government of New Brunswick renew its commitment to the Integrated Service Delivery Program as a philosophy and lynchpin of service coordination for children and youth across government by taking the following legislative, administrative and educational measures:

A. Integrated Service Delivery should be given a legislative framework through the new Child Wellbeing legislation being proposed to replace the *Family Service Act*; the centre of responsibility for ISD should be moved from EECD to the new Secretariat proposed in Recommendation I under the Minister for Child and Youth Services; the ISD governance structure should be recommissioned as the Interdepartmental Committee for Children and Youth; be supported by the Secretariat through an Executive Director, as well as a Clinical Director and a staff complement of members responsible for ensuring quality assurance across the regions, education and training and human resource recruitment and retention; and the legislation should require a periodic five year evaluation and review of ISD services as part of a process of continuous improvement;

B. The executive director of ISD should develop a new strategic plan for ISD in consultation with the Interdepartmental Committee and with children and young people themselves to implement needed reforms.

In carrying out the law reform and strategy development recommended above government should also consider the following suggested measures for improvement stemming from the Advocate's review of Youth Suicide Prevention and Mental Health Services:

i. The need for an ISD common plan for every youth admitted to a hospital psychiatric ward that will address immediate therapeutic programming needs and post-discharge planning;

ii. Better coordination between ISD child and youth teams and children and youth with open child protection files or Youth Justice Committee files;

iii. The urgent and priority deployment of ISD in all First Nations Communities in accordance with cultural safety adaptations required by communities;

iv. Ongoing implementation and monitoring of the new ISD practice and fidelity standards at the provincial level to ensure quality service delivery equally across all regions;

v. Review of ISD standards and indicators based upon the Family Engagement Quality Standards from the Ontario Centre of Excellence for Child and Youth Mental Health and the ACCESS Open guidance documents for Peer Mentors;

vi. The review of parental consent requirements for ISD programming supports to ensure that parents cannot arbitrarily withhold ISD supports against a child's best interests and to ensure that a child or youth's consent is always sufficient provided capacity concerns are satisfied;

vii. The development of a formal ISD resource plan to ensure that all children across all school zones benefit from ISD supports as much as possible within a same day referral model of intervention, using single session therapy interventions where appropriate, filling existing vacancies in child and youth psychiatrist, psychologist, social worker, school psychologist, school counselor, methods and resource teacher, guidance teacher, school social worker and behaviour intervention worker positions across all school districts, health authorities and community based partners and increasing the resource allocations to those positions where needs require it;

viii. The development of a formal ISD Training Framework, integrating Child rights based approaches, trauma informed care and the Stepped Care Model across all C&Y teams through cross-training opportunities with front line staff and specialists in related child and youth health, education, child welfare and child justice services. This should also include improved information sharing multidisciplinary teams practices;

ix. The review of ISD programming supports including:

1. Consideration given to the opportunities for improved care through telehealth, virtual health and electronic medical record supports to ISD as recommended by the NB Medical society;

2. Implementation of a structured protocol to guide ISD clinicians in receiving clients after completion of private counselling to ensure a seamless transition in services;

3. The need for expanded engagement of community partners at ISD Child and Youth tables and in multi-disciplinary common plan meetings, processes and interventions, including in particular through closer collaboration with chapters of ACCESS Open Minds, community social pediatric centres, CMHA and The Link, where they exist;

4. The addition of private therapists to students' care teams, especially when the youth has established a strong rapport and relationship with this person;

5. The development of improved capacity through C&Y teams and Child Welfare law reform, to address school absenteeism;

6. More efficient C&Y team processes to provide rapid access to care;

7. More clinical supports for children and youth through evidence-based interventions delivered via ISD teams, including Dialectical Behavioural Therapy (DBT); and

8. The development of a robust monitoring system to monitor the programs successes and replicate them provincially.

Child and Youth Participation: Nothing about us without us

Another central aspect of the reform of child and youth mental health services and suicide prevention that New Brunswickers would like to see, and that youth have insisted upon, is an improved commitment to child and youth participation in the policy development and monitoring process. During the course of this review, researchers at McGill University reached out to the Advocate's office, and other New Brunswick stakeholders, as part of a global study on child and youth participation in health and youth mental health policy processes. The literature review they shared with us in advance of their key informant interviews points to the strength and emergence of youth participation practices in this field across the globe.

We also were able through this review to rely upon the advice of our youth advisory council, its co-chairs, the participation of the FJFNB, Partners for Youth, Inc., the Youth in Care Network and many New Brunswick children and youth, including those who completed our survey, those who participated in our online public consultations, our listening tour with First Nation youth and communities, and some who shared in our Review's alternative forms of expression channel via our website. From these several sources we feel that we were able to develop a good sense of what New Brunswick youth would like to see happen in relative priority for reform in this field.

Among the many suggestions we heard we can note the call for school based navigational supports for youth seeking mental health intervention supports, repeated and strong calls for support to The Link Program, young people are asking for training so that they themselves can become the navigational supports and peer supports that their own peers need. Young people know that when mental illness manifests itself, youth peers will be among the first persons that children and young people will turn to for support. They are asking for training in order to be better allies in these situations. They also want more follow-up services when they do reach out for mental health supports, so that youth do not feel abandoned by the system. They want access to services in their own language as was stated in plain language in the brief submitted by the FJFNB. They want more clinicians available in a timely manner. They cannot be waiting for days, weeks and months when they are in crisis, or even when they are not yet in crisis. They are calling for mobile crisis units to be available at all hours knowing that mental health crises can occur at any time. They are aware of youth victims of sexual trauma, youth struggling with body image, eating disorders and other complex diagnoses requiring intensive supports and they want more services and supports in these areas. They were also asking for new investments in prevention and early intervention services. We know that many mental illnesses are episodic and that symptoms can worsen with successive episodes. Early intervention is therefore crucially important, and the Advocate strongly supports the FJFNB's call for improved early intervention supports.

We also heard the youth in our public consultations calling for improved resourcing of youth programs and support groups within community settings, including summer camps for mental health, online supports, phone apps, volunteering and mentoring opportunities, connections for at-risk youth, animal therapy and broad availability of the *Changing Minds program*. They want more wellness surveys in schools to encourage self-assessment and they want mental health supports upon leaving school or college to support their transition into the workforce. They have suggested student loan forgiveness for those who want to pursue careers in mental health support professions and other incentives for youth to choose these career paths.

They recommend sponsorship opportunities for children who cannot afford to take part in extra-curricular activities. They want support groups for families to discuss stigma surrounding mental health, suicide and grief. They welcome intergenerational programs where youth are invited to live with seniors as allies in their care. They want more training and education about the history of Indigenous peoples, but also about LGBTQIS+ issues, in order to address stereotypes and reduce discrimination and racism in health and educational systems. They want more sensitivity training about Mental Health and empathy training for all professionals in health and educational sectors and other frontline supports (policing, first responders, etc.). They also recommended youth lead support groups and Peer outreach programs, and free drop-in clinics with mental health programming and services available to youth on a 24/7 basis. We are encouraged by government's commitment to fund up to six ACCESS Open Minds sites across the province. The Program expansion should also be evaluated with a view to extending it to all parts of the Province. The early research suggests that this program pays for itself in reduced health care costs leading to savings of $1.40 for every dollar invested in the program, as of year one.[64]

It is clear from all of the excellent suggestions advanced by youth that they are indeed experts in their own lives. They can help identify the issues and advise upon what will work and what won't. But they are also asking for better oversight of all youth mental health and youth health services generally. The Advocate's central recommendation on this topic is that, as a critical aspect of that improved oversight, we devise sustained and better ways of involving young people in all aspects of decision-making in this sector.

Recommendation VI

It is recommended that children and youth from across the province be invited to constitute a Provincial Child and Youth Health Rights Advisory Council and that this provincial council designate its representatives to the Interdepartmental Committee on Children and Youth. This council should be funded by the Secretariat for Children and Youth and supported through the participation and logistical support provided by the Child and Youth Advocate's Office. This Provincial Advisory Council should reflect the diversity of New Brunswick youth and meet at least quarterly. It should also establish its own Action Plan in order to ensure that:

i. Children and young people are provided opportunities to participate in and inform the direction of local and school-based and college-based supports and programs for youth mental health and suicide prevention;

ii. Community-based programs such as ISD Child and Youth Teams, ACCESS Open Minds sites and Social Pediatrics clinics are also supported by active Youth Councils to reinforce the principle of child and youth participation and Nothing about us without us;

iii. The expert suggestions of New Brunswick children and youth outlined above, elsewhere in this Review and in future consultations are followed and diligently implemented including especially:

a. Improved training in schools and community for youth to help them recognize and effectively assist someone needing mental health or suicide intervention supports;

b. Additional services and supports for child and youth victims of sexual trauma as well as youth struggling with body image and or eating disorders;

c. Improved sensitivity training about mental health, as well as empathy training informed by child rights-based approaches, for all educational and health sector staff;

d. Additional sensitivity training in relation to LGBTQIS+ issues and Indigenous history in order to eradicate discrimination and racism in New Brunswick public services and society;

e. Improved funding of community-based interventions and supports for youth including through summer camps, leadership programs and other strength-based and peer led programming; and

f. Timely and rapid access to expert clinical care in the official language of one's choice.

The four criteria of the right to health care:

There are many aspects of the right to health care for children and young people that require study, careful consideration, definition and policy development. It is helpful however that the Committee on the Rights of the Child has adopted four criteria to guide the responsible implementation of health services. The criteria of Availability, Accessibility, Acceptability and Quality are commonly referred to as the AAAQ Framework. These criteria were first proposed by the Committee on Economic, Social and Cultural Rights (CESCR) as general criteria for the implementation for such rights and they have been frequently developed and applied in the education sector. They can be applied to a given treaty or body of rights such as the UNCRC, the *Convention on the Rights of Persons with Disabilities* (CRPD), or other human rights treaties, but they are also frequently applied to help understand the requirements of specific rights, or aspects of those rights, under a given Convention, for instance in relation to the right to clean water.[65] They are therefore well indicated to serve as general standards for multisectoral health initiatives.

We have found them to serve as an excellent analytical approach for improving youth suicide prevention and mental health services in New Brunswick, both in relation to the findings of our case study of Lexi Daken's death and the findings of our broader systemic review of the issue.

Availability

Availability refers to the existence of services. Are services available in sufficient quantity and type?[66] Our review has confirmed that in New Brunswick we are experiencing significant problems with respect to the availability of youth suicide prevention and mental health services.

In their submission, the New Brunswick Medical Society confirmed that in March 2021, near the time of Lexi's passing, there were 24 vacancies in psychiatry in New Brunswick. We also confirmed that school districts had more than half of their allotted psychologists positions left vacant at the same time, in addition to the numerous vacant psychologist positions within regional health authorities. We have reviewed the department of health's recruitment and retention strategy for psychiatry and psychology and are encouraged by the existence of this plan, but what New Brunswickers need are results. We simply cannot guarantee the right to life and the right to health for youth in this province, without the clinical experts needed. And we need more clinicians than we could have by simply filling the vacant positions. Even if all positions were filled, we would still not have enough child development and child and youth mental health specialists within psychiatry and psychology.

There is universal consensus among all stakeholders that we heard from that the shortage of available mental health clinicians has become a critical problem affecting access to services. The New Brunswick Medical Society made the call for a provincial mental health resource strategy their lead recommendation for reform. This lack of clinical mental health expertise is exacerbated by the shortages among nursing staff and family physicians in primary care settings, which also makes access to mental health care much more difficult.[67] The College of Psychologists for New Brunswick (CPNB) made it the concluding aspect of their brief, calling for improved efforts to reduce waiting lists for care, and new investments to train more mental health professionals, not only to meet demands for crisis supports, but critically to provide new and better prevention and early intervention supports. The FJFNB made this same point its lead recommendation, calling on government to make important new investments in mental health prevention and early intervention services. The Advocate agrees with these recommendations and urges Government to make the necessary investments to guarantee the right to health and the right to life for all New Brunswick youth by making youth mental health services and suicide prevention services more broadly available and in sufficient quantity to meet demands in a timely fashion. As stated by the CPNB in their brief:

> Waiting lists for mental health services in New Brunswick are too long. This is important because we know that barriers to care, such as long waiting lists, can discourage youth from seeking treatment, increase the severity of their problems, and create a negative relationship between seekers and service organizations. We also know that long waiting lists for care increase the likelihood that youth will require crisis services in the Emergency Department. Increasing community based services, where mental health treatment can be most effective, to reduce overreliance on crisis services should be an important goal for our province moving forward.
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> Timely access to appropriate and desired services is necessary. This is particularly relevant given the rural nature of NB. While barriers to care such as waiting lists are generally uniformly endorsed by urban and rural populations, rural populations tend to report being a long distance from available services (often compounded by transportation challenges), a lack of available services and a limited number of qualified mental health professionals nearby, and inconvenient hours of service provision.

The Advocate heard not only about the lack of availability of services in crisis setting and in community, we also heard a lot about the lack of availability of mobile crisis services in community. Stemming from our Connecting the Dots report in 2008, the implementation of mobile crisis units to send mental health experts as first responders rather than police to mental health crisis situations was heralded a major improvement in services. Over the years however we have heard time and again as advocates the frustration among families and group home workers that mental health mobile crisis units are not available when you need them. A time-limited response is not what is needed to make mental health services available in sufficient quantity. We welcome the many suggestions from youth, from parents, from educators and service providers, for a 24/7 mobile mental health crisis unit support service. Child protection social workers are used to the requirements of emergency response. A similar work schedule could be arranged to provide province wide emergency response for mental health crises at the community level. Much of this could be done through a realignment of existing resources without too much of an imposition on existing schedules. The New Brunswick Association of Social Workers suggests that the 811 phone line and the Mobile Crisis Units work together in order to offer an "on-call in-person response model" which is able to provide face-to-face intervention from on call social workers when needed. The St. Thomas University School of Social Work and the New Brunswick Medical Society (NBMS) have suggested further that mobile mental health units and clinics should be expanded in rural areas, including through the use of pop-up mobile clinics and virtual health care clinics.

We know that these investments in community-based supports cannot be made without ongoing investments required in formal systems of care. We need to meet existing needs, make the up-front investments in community-based care and expect to reap the benefits of these investments in future years. But bridge funding is needed to successfully carry out this service transformation from crisis-based late-stage intervention to community-based early-stage interventions.

Recommendation VII

It is recommended that the Province of New Brunswick make sizeable new investments and concerted efforts to address the shortage of mental health professionals and make the mental health services more broadly available to all children and youth in New Brunswick through the 2021-2023 period, in keeping with its legal obligations under Article 24 of the UN Convention on the Rights of the Child, through the establishment of a child and youth budget process by the Secretariat to track year over year investments in services to children and youth. Specifically, it is recommended that the Province at the direction of the Department of Health and the Interdepartmental Committee on Children and Youth and its Secretariat address this crisis in available services through the following measures:

i. The development of a youth mental health and suicide prevention human resource plan for the province of New Brunswick to address the critical shortage of psychiatrists, psychologists, mental health nurses and social workers, licensed counselling therapists and school behavior intervention workers and therapeutic foster parents and special care home staff; the plan should look to the career development and post-secondary training needs to meet demands in New Brunswick over the next fifteen years and develop effective incentives to aid with recruitment, retention and career training goals;

ii. The appointment and or designation of dedicated physician and professional mental health staff recruiters mandated to put into effect the recruitment of child and youth mental health professionals in accordance with the youth mental health and suicide prevention human resource plan;

iii. The youth mental health and suicide prevention human resource plan must be developed in tandem with and as an aspect of the Provincial Action Plan for Child and Youth Mental Health and Suicide Prevention and it should establish measurable benchmarks and indicators to monitor our progress as a Province, through ISD and other measures, in eliminating wait-times for child and youth mental health services;

iv. The development of extended mobile mental health crisis units available across the Province on a 24/7 basis to intervene as first responders in situations of mental health crisis when and where they occur;

v. The development with ISD and allied health partners of a Youth Mental Health Prevention and Promotion Strategy, within the overall Action Plan, to include bridging investments that will reduce the need and demand for hospital-based care and subsequently allow resource reallocation to community-based care throughout New Brunswick; this earlier intervention in the community will be more effective when mental health problems present in young people and will equip all children and young people with the wellbeing and wellness training needed to reduce the onset and incidence of mental illness to the greatest extent possible thereby enforcing their right to the enjoyment of the highest attainable standard of health and their right to life, survival and maximum development;

vi. The prevention focus in the above-noted Strategy should address all child and youth prevention needs using social determinants of health and life cycle approaches and looking to the needs of children youth from the moment of gestation and birth preparation forward; the particular needs of vulnerable populations including Indigenous children, LGBTQIS+ children and youth, immigrant and cultural minority youth, official language minority youth and disabled children and youth with disabilities including Foetal Alcohol Spectrum Disorders (FASD) and other neurodevelopmental disorders should be particularly considered and effectively addressed and monitored through the Strategy;

vii. The development of revised hospital staff plans of establishment to ensure the availability of sufficient clinical resources in a distributed capacity across the province, in accordance with the provincial youth mental health human resources plan, to meet local demands for youth suicide prevention and crisis care in youth mental health services, particularly in relation to psychiatry and psychiatric nurse supports in emergency wards and in child and adolescent psychiatry wards and pods;

viii. The development of specialized secure mental health consultation rooms in emergency wards, with sufficient beds and staffing throughout the province to be able to meet crisis demands where and as they present.

Accessibility

Accessibility is a broad term which includes many components including:[68]

- Physical accessibility: are services within safe distance, free from physical barriers?
- Financial accessibility: is the service accessible in terms of costs? Considering both direct costs such as service fees and indirect costs such as transportation?
- Administrative accessibility: is the service accessible for all clients? Is it available only upon referral? Is there a complex registration process? Does it require a fixed address, banking information? Are supports available to people with low literacy?
- Social accessibility: is the service accessible without stigma? Are all clients welcome without discrimination? Are supports available to facilitate accessibility in both official languages as well as to minority linguistic communities? Are the hours of access accessible to all clients including young people, or single parents?
- Informational accessibility: is the service accessible to all by being broadly known and advertised to all potential clients? Will client information be treated confidentially?

Having regard to this broad definition of accessibility, we note from our findings outlined above that there are many barriers to accessible youth suicide prevention and mental health services in New Brunswick. The most significant challenges that were brought to our attention focused upon financial accessibility, physical accessibility in terms of proximity to clients and hours of operation and informational accessibility in terms of youth, family and even service providers themselves simply not knowing enough about what services are available in order to be able to navigate themselves or others towards those services, if they are available.

Recommendation VIII

It is recommended that the Action Plan for Child and Youth Mental Health and Suicide Prevention implement concrete measures to guarantee the right of New Brunswick children and youth to enjoy the highest attainable standard of health and protect their right to life, survival and maximum development by improving the accessibility of child and youth mental health and suicide prevention services as follows:

i. Improved coordination of all available navigational supports must be prioritized so that every door a child or youth knocks on to receive mental health and suicide prevention supports becomes the right door; this will require sustained investment in favour of informational accessibility, to maintain and expand The Link Program while better integrating its resources into local ISD child and youth teams, and building upon these local collaborations to improve and keep current 211 and 811 services as well as networking with and relying upon the navigation supports of other emergency supports such as Kids Help Phone, Strongest Families and community intervention specialists such as ACCESS Open Minds sites, Social Pediatrics clinics, Child Advocacy Centres, local CMHA chapters, Atlantic Wellness, etc.

ii. Financial accessibility of youth mental health services and suicide prevention services must be addressed by: expanding free counselling services along the model of Atlantic Wellness Centre; expanding the coverage of employee benefit programs to routinely offer up to twelve sessions of psychotherapy or counselling rather than six; develop a provincial plan to gradually expand the scope of provincial medicare coverage to mental health counselling or psychotherapy when prescribed by an attending physician beginning with children and extending to young people up to 30 years of age; and ensuring the universal scope and reach of ISD supports and services to ensure that Child and Youth teams support tertiary complex needs youth as well as interventions with any child or youth presenting with mental health symptoms and primary prevention services aimed at all children and young people;

iii. Emergency departments should all have expanded hours of ER psychiatric nurses and social work supports to deal with any mental health emergencies when and as they present rather than treating mental health crises as emergencies that can wait;

iv. The guarantee of accessibility to these health services in New Brunswick has to be predicated upon the equal access to quality services in both official languages, without exception; increased investment is required to guarantee equal access to mental health services for New Brunswick youth from the francophone minority community across the province, as well as to anglophone minorities where they exist;

v. Rural communities and vulnerable population sectors including First Nations children and youth on and off reserve, immigrant youth, LGBTQIS+ youth, child victims of abuse and sexual trauma, children and youth with disabilities or mental disorders – including youth with FASD, youth with eating disorders and children with autism spectrum disorders should all benefit from expanded service options to make youth mental health and suicide prevention services more directly accessible to them in culturally safe, non-discriminatory, non-stigmatizing environments, including through the provision of transportation supports to access these services and the expanded use of virtual health and mobile health services to connect them with care.

Acceptability

Acceptability is about whether the health services provided are appropriate for the intended client in terms of cultural norms, standards, traditions and approaches, but also whether they satisfy applicable medical and professional standards and ethics. Are the services gender and age sensitive? Is patient confidentiality respected?

In this context our review has also found that there is much room for improvement in guaranteeing the right to health and the right to life in ways that meet the applicable human rights criteria of acceptability of services. The overarching problem is the lack of age sensitive services across health care systems. While, most hospital based and specialist referred health services recognize the value in specialized services in maternal and infant care and neo-natology and pediatric services, pediatric specializations for all aspects of health services are hard to find in New Brunswick and mental health services is no exception. Most hospitals lack the specialized facilities to adequately serve pediatric psychiatry patients.

The pediatrics wards generally do not have the safety standards in place that psychiatric patients require, and the psychiatric wards are not child-friendly and rarely appropriate for pediatric patients. Where specialized pediatric psychiatry wards or pods have been developed they often lack the staffing and programming and infrastructure supports to make healthy living environments for recovery, and youth situated there are often bored with little to do with their days.

Emergency wards are also not child and youth friendly and they are especially not welcoming to child and youth mental health patients. One youth who was seen in emergency earlier this year came forward to tell us that her treatment at her local hospital emergency ward was such an ordeal that she vowed never to return there to access services under any circumstance. The thrust of her objections to the care she received had everything to do with the belittlement, the lack of empathy and support, the lack of actual assistance rendered and the strong message she received that she was a malingerer and a burden to the system, who did not warrant the attention she was seeking. Like Lexi she was presenting there because of suicidal behaviour.

Acceptable services within ethical and medical standards would intervene with children and young people with respect for their inherent human dignity and the developmental stage of life in which they find themselves. Acceptable services would ensure that suicidal behaviour is taken seriously at all times, and especially whenever there is a history of prior suicide attempts. Acceptable hospital-based services would be informed by the knowledge that suicide is the second leading cause of death among young people and that suicidal ideation presents in adolescence with a far greater incidence that in any other stage of life[69]. Acceptable medical services would understand how challenging adolescence and early adulthood can be. Protocols would be established to ensure that patients at risk are not discharged without expert specialist assessment, nor without safety planning intervention and follow-up care. Existing protocols that insist that emergency ward staff refrain from using "No harm contracts" or "Suicide prevention contracts" would be strictly enforced and youth would not be placed under pressure to make decisions regarding their own discharge on the basis of any promises made.

Community Mental Health Standards need to be revised to establish dedicated access standards that are child friendly, aligned with ISD practice standards and provide reduced wait-times for children and young people with the goal of offering immediate connections to care based upon the severity of needs, but ensuring that no youth should have to wait more than 3 to 5 business days for a connection to care.

When presenting to the emergency department, patients with mental health concerns, like all other patients, are triaged using the Canadian Triage Acuity Scale (CTAS). This assessment includes a scale to rate physical pain intensity from 0-10 but does not account for psychological pain. The absence of an evidence-based prioritization assessment tool for patients in mental distress results in longer wait times for suicidal patients because they are not triaged as a high priority in terms of physical emergency. Acceptable emergency ward triage services would incorporate a validated mental health triage assessment as part of the protocol for mental health and suicidal patients and would prioritize child and youth patients within that cohort based upon the statistically greater risk of harm they face. Part of the solution here may be through better use of specialized mental health social workers in acute care settings to help with mental health triage and discharge planning functions.

Through our review we found that suicide risk assessments are not routinely performed on patients who present to the ER with suicidal ideation despite being part of the *2018 Horizon Health Network Emergency Department Standards, Chapter 4: Mental Health in the Emergency Department: "a suicide risk assessment is completed by a trained member of the health care team."* Additionally, *Appendix E: Suicide Risk Screening* includes an example of a suicide risk screening questionnaire that may be used by ER staff (Saskatchewan Ministry of Health (2011) Saskatchewan Suicide Protocols For Saskatchewan Health Care Providers Framework for the Assessment and Management of People at Risk for Suicide). Although this practice guidance is clearly spelled out, none of the DECH hospital staff we interviewed in relation to Lexi Daken's death, when asked about suicide risk assessments, could identify a standard tool that is routinely used on their patients. The ER physician was also unfamiliar with this type of mental health assessment. Acceptable health services, within the meaning of a child's right to life and right to health services, would ensure that an approved suicide risk assessment tool be used as part of a standardized protocol in assessing patients who present with suicidal ideation at the emergency room. This assessment would be provided within a reasonable length of time by a trained health care professional so that the patient's despair does not intensify. Many emergency department staff working with patients would be trained to administer this tool. Youth triaged as being at low risk of suicide must also receive appropriate discharge planning and community-based referrals to supports for their presenting problems. Early intervention in this context is the best, most timely and often the most important intervention health services can provide. Indeed, some experts are calling for suicidal risk assessment as a universal screening tool in pediatric Emergency Departments, pointing to a two-fold increase in suicide risk detection.[70]

The strong and repeated calls for empathy training in emergency rooms, as well as across hospital-based care and in educational settings, that we have heard through this review speak to the challenges that we face as a Province in providing acceptable care. In all of the cases we heard about, children and young people already have to overcome the double stigmatization of being young and being a patient with a mental health condition. If they happen to be of a racial or linguistic minority, or indigenous, or gay or lesbian and transgender, or have any other disability or neurodevelopmental delay, the challenges in finding acceptable health services can be even greater.

We also heard at length about the need for culturally safe and culturally based health practices when addressing suicide intervention and mental health services for indigenous children and youth. This is one area where the Province may be upon the cusp of exciting new changes, some promising practices are emerging, such as the dream catcher model of intervention developed by the FASD Centre of Excellence, and new opportunities for land-based healing such as the Lonewater Farm, but in the main, all of the work to transform health interventions towards culturally based and safe ones remains to be done. The recommendations outlined above and the commitment towards an ongoing process of review and policy development led by First Nations Communities and the commitment to fund ACCESS Open Minds sites in Elsipogtog and Tobique are encouraging next steps in developing acceptable youth mental health services for First Nations communities.

Girls will express suicidal ideation more frequently than boys but boys and young men will commit suicide more frequently than girls or young women[71]. A previous suicide attempt is one of the strongest predictors of youth suicide. Suicide attempts are twice as common in females than males[72].

However, about 25–33% of all cases of suicide were preceded by an earlier suicide attempt, a phenomenon that was more prevalent among boys than girls[73]. Certain diagnoses, such as eating disorders are more common in girls than in boys and the impacts of all forms of gender-based violence are experienced very differently by children of either sex, or LGBTQIS+ children and youth, and so attention must be paid in providing acceptable health services to the gender dimensions of care and the experience and incidence of poor mental health.

Recommendation IX

It is recommended that the Provincial Government renew its commitment to providing acceptable child and youth mental health and suicide prevention services, both in relation to cultural safety and in relation to medical ethics and health practice standards, to all children and young persons in New Brunswick without discrimination through the adoption of effective measures in the Action Plan for Child and Youth Mental Health and Suicide prevention, as follows:

i. The Department of Health and Health Authorities need to take effective measures to reinforce the delivery of adapted and specialized care for child, adolescent and young adult patients in all mental health care settings. Policies and practices need to be adapted to ensure that children and young people receive care and intervention that is consistent with their rights, their needs and their stage of development in life;

ii. All regional hospitals must have the ability to admit child and youth psychiatry patients in specialized units that are adapted to the level of risks they present as well as to their developmental needs and preferring placement in pediatric care over psychiatric care whenever appropriate;

iii. Protocols and practice standards in emergency rooms should be revised to ensure that: all mental health patients presenting at emergency are triaged in accordance with a validated mental health triage assessment tool and that child and youth patients are treated in relative order of priority; child and youth mental health patients presenting at emergency should all receive a formal suicide risk assessment using a validated screening process administered by a trained mental health clinician; practice standards requiring the avoidance of "No suicide, no harm contracts" with child and youth mental health patients should be stringently enforced; all staff are trained in relation to the risks of suicidality in adolescence and young adulthood, on how to intervene effectively and empathetically and that quality assurance mechanisms are enforced to ensure that discriminatory, derogatory, racist or inappropriate staff/patient interventions are reported, addressed and eradicated; and that upon discharge from the emergency department, each suicidal patient and their family is given the opportunity to create with a properly trained clinician a safety plan developed in accordance with validated tools such as the National Suicide Prevention Centre's Patient Safety Plan template[74] that clearly outlines patient-specific: triggers, coping strategies, people to call/ask for help, crisis plan and helping resources, ways to keep the environment safe (remove means of suicide), and offers the patient reassurance that recovery is possible provides them with a safety plan that leads to that recovery;

iv. Community Mental Health Standards should be revised to better align with ISD, distinguish between child and youth mental health patients and adult patients and implement connection to care standards that favour same day connections to care and ensure no delays greater than 3 to 5 business days for those connections for child and youth patients;

v. All child and youth mental health services, whether in community or in hospital settings, should undertake internal services reviews to ensure that their services are culturally and medically acceptable for all their client groups having particular regard to vulnerable populations including FASD children and youth, children and youth with other neurodevelopmental delays or disabilities, immigrant and refugee children and youth, official language minorities, Indigenous minorities, victims of trauma and neglect, including victims of sexual abuse and all forms of gender based violence.

Quality of Care

Quality care refers to whether child and youth mental health patients receive services from properly trained professionals, whether the treatments and medications they receive are properly dosed, stored and administered, whether the service environment is safe, sanitary, confidential and appropriate. Quality also encompasses how children and youth are treated before, during and following their access of services.

While our review revealed a number of instances where families came forward to point out the quality of care that they had received from a given community-based or hospital-based service provider or team, the Review also heard a great deal about how quality of care could be improved in child and youth mental health service delivery.

As outlined above one of the key problems we noted in our review was that while standards and practice protocols may need revision and updating the greater challenge is actually in making sure that all staff are sufficiently trained to know about the relevant practice standard and when and how to implement it. The challenges noted in lack of empathic care are undoubtedly fuelled by operational pressures, staff shortages and underfunding, but they also point to a lack of training. This is true in hospital-based care, but also in relation to ISD and other forms of community-based care.

Through this review and earlier through our own caseload as Child and Youth Advocates we have noted in many files a lack of appropriate discharge planning to make sure that children and youth being discharged from hospital following mental health services or a suicide risk assessment are equipped with all the guidance they need to stay safe and access follow-on supports in community and know how to connect back with care.

Recommendation X

It is recommended that the Government of New Brunswick take early and effective steps to improve the quality of services in child and youth mental health and suicide prevention in full implementation of the right to life and right to health, as follows:

i. Hospitals should implement in their systems of continuous improvement and quality assurance regular child and youth mental health and suicide prevention updates to review existing protocols and practices and discuss cases and emergent practices in all appropriate forum, including Emergency Department meetings, Quality assurance meetings, nursing staff and physician staff meetings, etc. ; the development of new protocols or changes to existing ones must be clearly communicated to all affected staff and ensure that representatives from all teams are involved in any decision-making regarding changing or developing protocols that relate to their work;

ii. The recommendations for compassionate Caring Crisis Care in the Advocate's Interim report *A Matter of Life and Death*, should be extended to offer the same training and professional development programs to non-crisis care mental health services staff and frontline staff in child and youth serving departments and agencies; the training programs provided should integrate trauma informed care and child rights based approaches and include tailored interventions for vulnerable population groups;

iii. Social workers in schools, community and in hospital settings should be also be trained, instructed and equipped to assist with the response and supports to child and youth clients who present with suicidal thoughts or behaviour;

iv. Personal wellness classes need to be integrated as a mandatory part of the curriculum at each grade level, with measurable outcomes.

v. School curriculum needs to be enhanced so that young people receive mental health fitness training to be able to better address their own mental health needs but also be able to identify, address and respond effectively to peers who reach out for support or display a need for support; the training should also focus on how to avoid and address stigmatizing or discriminatory comments or behaviours by others;

vi. School curriculum and extra-curricular programming also needs to be reviewed in order to proactively develop resiliency factors among children and youth, starting in early years education and continuing throughout K-12 by promoting preventative, welcoming and thriving environments for learning as a wellness support; positive mental health strategies should be incorporated into all school plans and carefully monitored;

vii. Bachelor of education programs, social work programs, and programs in law faculties, medical faculties, police academies and nursing schools should be revised to ensure that all new professionals working with children and youth receive mandatory training in trauma informed care, social and emotional learning, child rights based approaches, youth mental health literacy and suicide ASIST training; Professionals already in these fields should receive mandatory in-service training and follow up evaluations to verify their competencies in these areas;

viii. The ISD Child and youth teams should implement quality assurance mechanisms across their services, including a revised uniform school-based youth mental health screening tool that is culturally safe and child rights informed to ensure that children and youth seeking to access care are properly triaged at the school level and that all pupils receive the timely interventions and supports they need to be ready to learn.

Prevention and Public Education

There are two remaining areas of recommendation stemming from our child rights based approach of the findings in this review: the area of prevention and education and the task of research and data collection in maintaining quality assurance and continuously improving interventions and services. Both of these areas have been touched upon above in our analysis of the criteria for enforcement of the right to health, using an AAAQ Framework, but both areas also require further discussion and recommendation.

For the Prevention and Public Education Focus we have outlined in the youth participation recommendation and in the AAAQ framework recommendations a number of paths to equip children and young people and professionals in various sectors with the knowledge and skills they need to intervene effectively with mental illness manifests itself in children and young people. The need scope of public education efforts must of course be much broader and reach all sectors of society. The Prevention focus has also been mentioned as a goal in a few of the recommendations above but we want to give this goal and service orientation greater focus by discussing it and providing a separate recommendation as we have below. The Review has confirmed a finding we have made in many cases that come to us at the Advocates office, that especially with mental health issues in young people, we intervene much too late. Not always effectively. Indeed one of the main story lines with child and youth mental health and suicide prevention services in New Brunswick stemming from our review is that our efforts can much too frequently be summarized as a case of too little, too late.

Many stakeholders emphasized to us the importance of investing in early years and indeed pre-natal preparations for lifelong wellness and positive mental health. Social determinants of health very often impact mental health before taking their toll in the form of other physical health and chronic health conditions. Casting a broad social welfare safety net is therefore often one of the best ways of preventing a greater incidence of mental illness and maintaining a healthy and productive labour force as an engine of economic and social progress. The College of Psychologists pointed out however in their brief that because discussions around suicidality often focus on crisis care and all services engaged in responding to situations where a given youth is actively suicidal, too little attention and discussion is focused on earlier upstream and preventative interventions. The high incidence, and the growing incidence, on child and youth mental health case presentations in the recent provincial data, as compared to the overall population, convinces us as Advocates that much more needs to be done to address this rise in cases from a preventative approach. We agree with the following passages from the CPNB's brief:

> Prevention programs work on the front end to build skills to promote positive mental health, wellbeing, and coping and prevent problems from developing. They also improve mental health education and facilitate early identification of the problems. Early identification of problems allows for early intervention and reduces the chances that problems will progress in severity, frequency, and intensity.
>
> We strongly recommend that the province invest in evidence-based prevention and promotion programs. There is an increasing literature that outlines the success of school-based mental health programming as one way in which programming can be implemented (Durlak et al., 2011; Mental Health Commission of Canada, 2013).

> Reducing stigma and normalizing help-seeking are important goals, as minimizing the severity of problems, a desire to handle problems independently, having negative stereotypes of treatment, being unaware of treatment options, and worries about stigma and embarrassment are important barriers to care (Collins et al., 2004).

We agree with these recommendations and with the need to extend prevention and promotion programs well beyond the school walls. Parent workshops, mental health literacy programs through library services, public health services and community partners, improved mental fitness and wellbeing conversations as routine aspects of primary health care, integrated wellness programming as an aspect of community youth programming and services, and early years wellness clinics for parents of young children are all needed to reorient our approaches as a Province and reduce the burden of poor mental health. As Advocates we have also always been strong proponents of resiliency training and positive well-being through improved investments in supporting the child right to play, rest, physical education, sports and recreation and participation in arts and cultural activities. A child rights based approach to mental health service reform would recognize the intersectionality and interdependency of all child rights to one another.

Beyond these general comments on the need to pivot away from crisis care and resolutely towards strength-based prevention approaches and investments, there are two important conversations which the Advocate is inviting New Brunswickers to have, as aspects of this prevention approach. One is a conversation about the quality of family life in New Brunswick. The second is the need to talk about the runaway problem of youth suicidality.

This review has prompted the need for us as advocates to raise these uneasy questions. Not especially because of anything that has come to light during the review, but more so because of the issues that have not. The issues that we hear much more about in our individual case advocacy, as we come to know the stories of the youth and families we work with over the course of months and years. Every aspect of this review happened rapidly because we wanted to act urgently and seize the opportunity and the commitment from Government to act decisively in favour of change and progress. This did not allow time for some of the more difficult conversations that New Brunswickers might otherwise have brought forward.

Medical evidence tells us that mental illness causes are multifactorial, including genetic factors as well as relationships with addictions and substance abuse problems. We know also that it is very much related to trauma and we know that much of that trauma happens within households and between family members, as well as within the larger context of school, community and social contexts that can contribute to toxic stress in children and youth. Children and young people are often traumatized as victims of abuse, or neglect, but also as witnesses of abuse. The toxic stress of family life in many situations can place a heavy and unfair burden on children and young people. Alberta Family Wellness offer a training program called Brain Story which could helpfully be integrated to our efforts to move towards prevention health practices in this sector.[79] Often times when we talk about mental health challenges we steer clear of this conversation because we do not want to stigmatize or call into question the family dynamics at play in any given situation. We all know full well that if we could magically solve all the problems of child abuse, neglect and intimate partner violence, that the challenges of mental illness would still be very much present with us.

But we know also that they would be greatly reduced. We would have taken a mighty weapon away from the arsenal of mental illness. And so as Advocates, because we are aware of this interrelationship between toxic stress within families and mental illness in youth we want to have this difficult conversation as a society. We want to ask what can be done to improve the quality of family life and children's best interests within families as part of this larger societal health challenge.

The second big conversation that we had hoped this review would help us resolve, but which we now realize will need more study, more planning and direction – and urgently so – is the problem of youth suicidality. In our consultation document we recalled the prior recommendations from our office and by our colleagues from across Canada for provincial and territorial youth suicide prevention strategies. With suicide figuring as second leading cause of death among young people, with Canada having one of highest youth suicide rates in the world and New Brunswick having the highest suicide rate in the country, this is a conversation that keeps staring us in the face and that needs to be urgently addressed. We had hoped to have a draft strategy by the end of our process that government could consider and quickly adapt. Our consultation did not get that far but we have prepared a background paper on youth suicide as an appendix to this report pointing the way forward for some strategies and we know that the good work done by the Department of Health in relation to the global provincial suicide prevention plan and the work done this year by the Coroner's Office and the Child Death Review Committee will materially advance this conversation and allow us to make swift progress in the coming months.

Recommendation XI

It is recommended that the Government of New Brunswick take early and proactive steps to significantly increase its investment in youth prevention and promotion programming to address youth mental health challenges and suicidality; these measures should include evidence informed school based and community-based programs targeting all population groups, including children and young people of all ages and should be tracked through the Secretariat's quality assurance process and budget for children and youth process to monitor year over year investment and outcomes from these upstream investments.

It is recommended that the Province of New Brunswick jointly with the Advocate's office, the Department of Health, the Coroner's Office, the Child Death Review Committee and all relevant stakeholders develop within the 2021-22 fiscal year a provincial youth suicide prevention strategy for the 2022-2025 three-year cycle, to be renewed in five-year cycles thereafter.

It is recommended that the Government commission a further study into the quality of family life for children and young people aimed at addressing the problem of toxic stress within families and its impact on youth resilience, achievement and mental health.

Investing in quality assurance, continuous improvement, data collection and monitoring and research

A final area for recommendation in this report is in relation to data and research. We know as Advocates that the two things that drive political change and reform in this province, as in many democracies, are powerful narratives and good data. We are hoping through our efforts to strengthen the case for a third driver of change and that is intentional, conscientious, programmatic human rights development. However, we assume that despite all our efforts powerful narratives, of tragedy, grief and loss will remain a constant and that, 75 years into the New World Order, the human rights agenda for change will not suddenly make new converts everywhere. Therefore, we also want to insist as Advocates on the need for good data stewardship in relation to youth suicide prevention and mental health services.

Our review has identified a number of knowledge gaps and a need for benchmarking and the identification of indicators and targets for improvement across a number of data points in relation to this matter. As a province we do not have a good handle on the incidence of youth suicidal ideation or the factors that most influence it. Our data in relation to completed suicides is questionable insofar as we have many overdose deaths and accidental deaths that might be counted as suicides if there was less stigma or better evidence of suicidality. In relation to diagnostic information by mental illness, our best data available is in relation to hospital admission data by diagnosis, but that is an indicator that we are intentionally trying to reduce and that does not adequately quantify the incidence of illness or the burden of disease. We should be collecting diagnostic information on youth mental health at the community level through ISD and making informed programming and policy decisions from that data repository.

The ACCESS open minds initiative in New Brunswick collected data from youth receiving services at ACCESS clinics through a national DACIMA research tool. It would be important moving forward with the provincial roll-out and funding of these community safe spaces for accessing care that the data collection and research efforts in relation to this model continue. One of the challenges in improving care in this field of health is to keep abreast of evolving interventions and treatments and ensure that young people benefit in a timely fashion from medical and clinical advances in treatment methods. Previous recommendations from the Advocate's office called for the establishment of two provincial research nodes in child and youth mental health, one at UNB and one at UdeM. At UdeM the Province helped fund a 10-year research chair in this field that is now in its sixth year of operations. Consideration should be given to the renewal of this research chair and the opportunity to establish a research chair at UNB perhaps in the field of youth suicide prevention or indigenous youth mental health.

All of these research and data monitoring efforts should be directed towards improving evidence-based policy making and guiding clinical care. The nexus between clinicians and researchers in this field needs strengthening in New Brunswick. In this regard our population is poorly served because of the nascent state of our medical faculties and the low numbers of research clinicians working in this field in New Brunswick. New Brunswick also has a poor record in terms of doing the solid evaluation and knowledge translation work on our own service innovations in relation to child and youth services including family group conferencing, ISD Child Rights Impact Assessment, the work of youth justice committees, or FASD interventions like the Dream-catcher model in order to publicize and sustain these models of service and intervention locally through national or global endorsement and uptake.

The Advocate would like to see strategic conversations happen with the Social Policy Research network, the New Brunswick Health Council and university research offices to advance research in all fields related to child and youth rights, and youth mental health wellbeing and resilience.

Recommendation XII

It is recommended that the Government of New Brunswick take effective and immediate measures, upon the direction and advice of the New Brunswick Health Council and the Child and Youth Advocate's Office, to improve quality assurance and continuous improvement in the field of youth suicide prevention and mental health services by investing in research, data collection and data monitoring efforts as follows:

i. The New Brunswick Health Research Foundation, in consultation with the Department of Health, regional health authorities, university research offices and the Advocate's office should develop a provincial plan to nurture and advance child right based approaches for child and youth health and child and youth mental health and suicide prevention in New Brunswick over the next ten years; consideration should be given to the development of New Brunswick medical faculties and of a New Brunswick Children's hospital as part of this plan;

ii. The Chaire de recherche en santé mentale des enfants et des jeunes (CRISMEJ) established at UdeM in 2014, should be extended for a further ten years from 2026 to 2036; a research chair at UNB should also be established in youth suicide prevention and/or in indigenous youth mental health through seed funding provided by the Province; the New Brunswick Health Research Foundation in collaboration with the Advocate's office should develop means to network the conversations between researchers affiliated with such research nodes and clinicians, policy-makers and practitioners in the field through newsletters, seminars, conference and regular network calls and events;

iii. Additional research chairs at Mount Allison, UNBSJ and St-Thomas university could be pursued as well, including a Canada Research Chair in best practices in Child Welfare as suggested by the STU School of Social Work;

iv. Ongoing program evaluation and policy reform and renewed evaluation has to be built in to all child and youth service interventions delivered or funded by the Province of New Brunswick; evaluation funding should prioritize implementation of recognized best practices being tested in New Brunswick including, social pediatrics in community pilots, child advocacy centres, the CMHA's Bounce-Back program for community-based Cognitive Behavioural Therapy (CBT) sessions, the Canadian Mental Health Commission's Roots of Hope initiative, etc.; improved indicators for child and youth mental health need to be developed and monitored;

v. As the Province moves into the recovery phase of the COVID-19 pandemic, data collection and research initiatives should continue to target research in relation to the COVID-19 impacts on children and youth to assist with their full recovery and address all impacts from the disruption of their education, to their experience of grief, loss and health insecurity, as well as the impacts of social isolation and the public health measures required to combat the spread of infection.

CONCLUSION

We have attempted in the preceding pages and with the twelve broad areas of recommendation outlined to chart a path for New Brunswick to achieve much lower rates of youth suicide and youth mental illness diagnosis and much higher rates of resilience and well-being among youth. The report calls for structural and fundamental changes to support that goal while also offering detailed processes, interventions and strategies to achieve the desired outcomes.

We have called for a new level of governance for all services to children and youth, with a Minister and Secretariat responsible, because we believe in the merit and promise of multidisciplinary practice and integrated service delivery. We are insisting upon a change that is driven by community, family and youth, because we know that these interventions are client-centred and bring health services down to the relational level of supports that children and youth need and crave. And we are calling for fundamental and principled change that is embedded in a commitment to children and young people as rights holders with their own special rights and interests, and with their own opinions and voices in terms of how best to carry out the reforms needed, including First Nations youth who have their own history of intergenerational trauma to overcome.

We recognize the constant effort for improvement that public service providers in this field are making every day. We celebrate the fact that we are now reaching out to many more children and young people with mental health supports than at any other time in our history. But we sense that the needs are now also greater than ever before and our review has confirmed that there is still much room for improvement. We have therefore included detailed recommendations on how to improve Integrated Service Delivery, as one of the lynchpins of our efforts in this field, as well as detailed recommendations on how to respect the child's right to life and to the highest attainable standard of health by committing ourselves to an accountability framework of child and youth health services that are Available, Accessible, Acceptable and of Quality. Finally, we recommend that Government invest more strategically in prevention and education efforts in this field as well as in quality assurance, data monitoring and research.

We are encouraged by the Department of Health's early endorsement of our interim recommendations and by the progress made in relation to the 21 recommendations endorsed by the Minister early in May, following the Department's own internal review of crisis care. We have noted that a number of the recommended changes, such as dedicated mental health observation rooms in emergency departments have already been implemented in some hospitals and are making a difference. We are committed to iproving our own process of quality assurance and recommendations monitoring as an Advocate's office and we pledge to report publicly every six months for the following two years on the progress of all recommendations from this review process and the minister's internal review.

It is possible that in our search for solutions and in our urgent effort to make the case for these changes that we have paid too much attention to the challenges and set-backs shared with us by individual New Brunswick families, or that we have failed to acknowledge sufficiently the dedicated professionalism with which nurses, doctors, social workers, teachers, guidance counsellors and so many others address day in and day out the pressing mental health needs of our children and youth. New Brunswick is made better because of those efforts and indeed because of the efforts of education and health professionals to have maintained essential services throughout these extremely trying pandemic times. We want in closing to recognize and emphasize our admiration for the constant efforts of all those who work in the demanding field of child and youth mental health services delivery.

Most importantly we want to urge these same professionals to join with us, with children and youth and their families and carers as suggested in the recommendations outlined above to work together with elected officials to carry forward the reforms needed. We are confident that it is only through such collective efforts that we will continue to make this province a better place for future generations.

APPENDICES:

Appendix I : Table of Recommendations

Recommendation I

It is recommended that the Province of New Brunswick appoint a Minister responsible for Children and Youth, that the mandate of this minister include youth up to the age of 25 and that the Minister be supported by a Secretariat for Children and Youth lead by its own Deputy Head. It is recommended that the Secretariat be responsible for the coordination of Integrated Service Delivery as well as the alignment of services to children and youth across government through the development of a Standing Interdepartmental Committee on Children and Youth. This committee should be responsible with the Secretariat for the training and implementation of Child Rights Impact Assessment and the development of a provincial Action Plan for Child and Youth Mental Health and Suicide Prevention.

Recommendation II

It is recommended that the Province's proposed Action Plan for Child and Youth Mental Health and Suicide Prevention should ensure measurable progress over the next five years in reducing inappropriate hospital admissions for youth mental health disorders and invest strategically in upstream prevention and early intervention community-based programs and supports in keeping with the Stepped Model of Care outlined in the Interdepartmental Addictions and Mental Health Action Plan. The new investments by the Province at the community level should be used to leverage local business sector and philanthropic sector contributions so as to maintain community-based ownership of the interventions. These interventions should be provincially funded based upon the best available evidence, properly evaluated, and their impacts supported by expert knowledge translation efforts.

It is further recommended that the Community engagement aspect of the Action Plan should be managed by community through the efforts of a lead non-profit sector agency acting as the convenor of these conversations, along the lines of the United Way Manitoba initiative supported by the Graham Boeckh Foundation. This backbone organization will ensure that the Action Plan is developed with the active participation of young people with lived experience of mental health services, their peers, family members and community allies. The organization will ensure that these members meet regularly through supported local and provincial forums as well as with the Interdepartmental Committee on Children and Youth to monitor the progress and implementation of the Action Plan.

For further specificity, the Advocate recommends that targeted community-based interventions be considered for funding including:

- ACCESS Open Minds site expansions
- Atlantic Wellness Center type supports
- The Link program chapter development
- Social Pediatrics in Community service points
- Indigenous land-based two eyed seeing interventions
- Child Advocacy Centres for child victims of abuse
- Sistema orchestral programs, local CMHA chapters, Boys and Girls Clubs, Big Brother, Big Sister chapters, local YMCAs, targeting youth mental health fitness and suicide intervention supports

Moreover, the Advocate also suggests that key components of the Action Plan recommended above should include training and professional development actions, public education and awareness actions, evidence-based prevention and promotion programs including school-based educational programs, peer based supports for youth and families, navigational supports, child and youth participation benchmarks, child right to health indicators as well as supports and mechanisms to network conversations amongst all child and youth mental health stakeholders across the Province.

Recommendation III

It is recommended that the proposed Action Plan for Child and Youth Mental Health and Suicide Prevention be embedded within a Provincial Strategy for Child and Youth Rights and that the service transformations it proposes be inspired by child rights-based approaches. The Action Plan should support significant multi-departmental and community sector cross-training efforts to retool educators, health service providers, child protection, justice and policing officials and their community allies with the knowledge they need to meet their obligations as duty-bearers to child and youth rights-holders and use rights informed approaches aligned with trauma informed care.

It is further recommended that in order to consolidate its principled commitment to child rights enforcement, the proposed Minister for Children and Youth and Executive Council Office take swift legislative action to incorporate the Convention on the Rights of the Child into our domestic law.

Recommendation IV

The New Brunswick Child and Youth Advocate endorses the following recommendations from Indigenous experts and allies:

It is recommended that :

A. The Mi'gmaq, Peskotomuhkati and Wolastoqey languages be formally recognized and supported by provincial legislation which:

i. Recognizes that these languages are the original languages of this territory, that Indigenous language rights are part of the Peace and Friendship Treaties and that these languages are currently endangered;

ii. Recognizes Indigenous languages as fundamental and valued in New Brunswick culture and society;

iii. Actively supports Indigenous language revitalization through funding and programs provided by the provincial government and/or in partnership with the federal government;

iv. Affirms that the reclamation, preservation, revitalization and protection of Mi'gmaq, Peskotomuhkati and Wolastoqey languages are best undertaken by these Indigenous peoples and communities.

SUICIDE PREVENTION, ADDICTIONS, AND MENTAL HEALTH SERVICES

B. Culture as Foundation and a Two-Eyed Seeing approach should be used as the basis for implementing mental wellness, health and addictions services for Indigenous youth. Culturally relevant services and programming should be available for Indigenous youth and families through:

i. Co-development with Indigenous peoples and communities;

ii. Indigenous-led community-based services as part of the continuum of services;

iii. Provincial health and mental health programs and services that meet the mental wellness needs of Indigenous people;

iv. Enhanced collaboration between provincial health services and First Nation communities and Indigenous organizations to ensure that Indigenous youth have a culturally safe and seamless experience when using health and mental health services.

HEALTHCARE SYSTEM

C. The Province of New Brunswick and Indigenous communities and organizations work together to effect changes in healthcare structures and processes, such as service design, policy, human and financial resources, program and service delivery with the longer-term goal of cultural safety and improved mental health outcomes for Indigenous people.

D. The Province of New-Brunswick establish a Tripartite forum and an ongoing process involving Indigenous leaders, Directors and organizations, provincial and federal governments to:

i. Develop a framework for culturally appropriate, competent and safe mental health services for Indigenous people;

ii. Improve access, provision and cultural competency and safety of mental health and wellness services for Indigenous youth;

iii. Include First Nation input and oversight on the Indigenous portion of funding and aspects of the Canada-NB Agreement on Mental Health and Addictions;

iv. Establish site(s) as Indigenous-led healing centre(s), (e.g., Lonewater Farm) and enable success with provincial property tax reform and long-term core funding for programming, staff training support, etc.

v. Provide integration of the provincial ISD teams and the Jordan's Principle staff to better serve the needs of Indigenous children and to create a cohesive jurisdictional approach to ensuring no gaps exist in services to Indigenous children.

FUNDING, PUBLIC AWARENESS/RECONCILIATION, AND RESEARCH

E. The Province of New-Brunswick increase transparency on federal health transfer dollars to New Brunswick and expenditures as these pertain to Indigenous mental health services.

F. The Province of New-Brunswick flow the First Nation portion of funding from the Canada-NB Agreement on Mental Health and Addictions through the Tripartite Forum.

G. The Province of New Brunswick fund a separate review of Indigenous youth mental health services, including a scan on a) jurisdictional gaps in service delivery and integration and b) adequacy of funding and services.

H. The Province of New-Brunswick resent the Indigenous Guidance Team recommendations on the Network of Excellence to Indigenous leadership, First Nation Directors of Health, Child Welfare and Education and Indigenous organizations.

EDUCATION

I. The Province of New-Brunswick institute Wabanaki culturally inclusive education policy and legislation at the early learning, secondary and post-secondary levels that upholds the Provincial Government's Constitutional obligations to Indigenous children to provide quality education and includes First Nations people in New Brunswick as residents of New Brunswick with a right to equitable provision of services that is free of systemic racism throughout their education.

J. The Province of New-Brunswick co-develop success indicators with Indigenous people for Indigenous youth in the education system that measure not only academics, but also the holistic needs of Indigenous youth, including their cultures, languages, access to ceremonial practices and mental wellness.

K. The Province of New-Brunswick re-invest 100% of the New Brunswick-First Nation Education Enhancement Agreement dollars to provide programming and services for Indigenous children.

L. The Province of New-Brunswick reinstate the First Nations Ministerial Advisory Committee that was part of the original Enhancement Agreements but has ceased to exist for the past eight years so that recommendations to the Minister will be heard and acted upon.

JUSTICE & PUBLIC SAFETY

M. Judges and Crown Prosecutors receive training on Indigenous intergenerational trauma and culturally relevant options for Indigenous youth who are in conflict with the law so they can better identify appropriate extrajudicial sanctions and sentencing options for Indigenous youth.

Recommendation V

It is recommended that the Government of New Brunswick renew its commitment to the Integrated Service Delivery Program as a philosophy and lynchpin of service coordination for children and youth across government by taking the following legislative, administrative and educational measures:

A. Integrated Service Delivery should be given a legislative framework through the new Child Wellbeing legislation being proposed to replace the Family Service Act; the centre of responsibility for ISD should be moved from EECD to the new Secretariat proposed in Recommendation I under the Minister for Child and Youth Services; the ISD governance structure should be recommissioned as the Interdepartmental Committee for Children and Youth; be supported by the Secretariat through an Executive Director, as well as a Clinical Director and a staff complement of members responsible for ensuring quality assurance across the regions, education and training and human resource recruitment and retention; and the legislation should require a periodic five year evaluation and review of ISD services as part of a process of continuous improvement;

B. The executive director of ISD should develop a new strategic plan for ISD in consultation with the Interdepartmental Committee and with children and young people themselves to implement needed reforms.

In carrying out the law reform and strategy development recommended above government should also consider the following suggested measures for improvement stemming from the Advocate's review of Youth Suicide Prevention and Mental Health Services:

i. The need for an ISD common plan for every youth admitted to a hospital psychiatric ward that will address immediate therapeutic programming needs and post-discharge planning;

ii. Better coordination between ISD child and youth teams and children and youth with open child protection files or Youth Justice Committee files;

iii. The urgent and priority deployment of ISD in all First Nations Communities in accordance with cultural safety adaptations required by communities;

iv. Ongoing implementation and monitoring of the new ISD practice and fidelity standards at the provincial level to ensure quality service delivery equally across all regions;

v. Review of ISD standards and indicators based upon the Family Engagement Quality Standards from the Ontario Centre of Excellence for Child and Youth Mental Health and the ACCESS Open guidance documents for Peer Mentors;

vi. The review of parental consent requirements for ISD programming supports to ensure that parents cannot arbitrarily withhold ISD supports against a child's best interests and to ensure that a child or youth's consent is always sufficient provided capacity concerns are satisfied;

vii. The development of a formal ISD resource plan to ensure that all children across all school zones benefit from ISD supports as much as possible within a same day referral model of intervention, using single session therapy interventions where appropriate, filling existing vacancies in child and youth psychiatrist, psychologist, social worker, school psychologist, school counselor, methods and resource teacher, guidance teacher, school social worker and behaviour intervention worker positions across all school districts, health authorities and community based partners and increasing the resource allocations to those positions where needs require it;

viii. The development of a formal ISD Training Framework, integrating Child rights based approaches, trauma informed care and the Stepped Care Model across all C&Y teams through cross-training opportunities with front line staff and specialists in related child and youth health, education, child welfare and child justice services. This should also include improved information sharing multidisciplinary teams practices;

ix. The review of ISD programming supports including:

1. Consideration given to the opportunities for improved care through telehealth, virtual health and electronic medical record supports to ISD as recommended by the NB Medical society;

2. Implementation of a structured protocol to guide ISD clinicians in receiving clients after completion of private counselling to ensure a seamless transition in services;

3. The need for expanded engagement of community partners at ISD Child and Youth tables and in multi-disciplinary common plan meetings, processes and interventions, including in particular through closer collaboration with chapters of ACCESS Open Minds, community social pediatric centres, CMHA and The Link, where they exist;

4. The addition of private therapists to students' care teams, especially when the youth has established a strong rapport and relationship with this person;

5. The development of improved capacity through C&Y teams and Child Welfare law reform, to address school absenteeism;

6. More efficient C&Y team processes to provide rapid access to care;

7. More clinical supports for children and youth through evidence-based interventions delivered via ISD teams, including Dialectical Behavioural Therapy (DBT); and

8. The development of a robust monitoring system to monitor the programs successes and replicate them provincially.

Recommendation VI

It is recommended that children and youth from across the province be invited to constitute a Provincial Child and Youth Health Rights Advisory Council and that this provincial council designate its representatives to the Interdepartmental Committee on Children and Youth. This council should be funded by the Secretariat for Children and Youth and supported through the participation and logistical support provided by the Child and Youth Advocate's Office. This Provincial Advisory Council should reflect the diversity of New Brunswick youth and meet at least quarterly. It should also establish its own Action Plan in order to ensure that:

i. Children and young people are provided opportunities to participate in and inform the direction of local and school-based and college-based supports and programs for youth mental health and suicide prevention;

ii. Community-based programs such as ISD Child and Youth Teams, ACCESS Open Minds sites and Social Pediatrics clinics are also supported by active Youth Councils to reinforce the principle of child and youth participation and Nothing about us without us;

iii. The expert suggestions of New Brunswick children and youth outlined above, elsewhere in this Review and in future consultations are followed and diligently implemented including especially:

a. Improved training in schools and community for youth to help them recognize and effectively assist someone needing mental health or suicide intervention supports;

b. Additional services and supports for child and youth victims of sexual trauma as well as youth struggling with body image and or eating disorders;

c. Improved sensitivity training about mental health, as well as empathy training informed by child rights-based approaches, for all educational and health sector staff;

d. Additional sensitivity training in relation to LGBTQIS+ issues and Indigenous history in order to eradicate discrimination and racism in New Brunswick public services and society;

e. Improved funding of community-based interventions and supports for youth including through summer camps, leadership programs and other strength-based and peer led programming; and

f. Timely and rapid access to expert clinical care in the official language of one's choice.

Recommendation VII

It is recommended that the Province of New Brunswick make sizeable new investments and concerted efforts to address the shortage of mental health professionals and make the mental health services more broadly available to all children and youth in New Brunswick through the 2021-2023 period, in keeping with its legal obligations under Article 24 of the UN Convention on the Rights of the Child, through the establishment of a child and youth budget process by the Secretariat to track year over year investments in services to children and youth. Specifically, it is recommended that the Province at the direction of the Department of Health and the Interdepartmental Committee on Children and Youth and its Secretariat address this crisis in available services through the following measures:

i. The development of a youth mental health and suicide prevention human resource plan for the province of New Brunswick to address the critical shortage of psychiatrists, psychologists, mental health nurses and social workers, licensed counselling therapists and school behavior intervention workers and therapeutic foster parents and special care home staff; the plan should look to the career development and post-secondary training needs to meet demands in New Brunswick over the next fifteen years and develop effective incentives to aid with recruitment, retention and career training goals;

ii. The appointment and or designation of dedicated physician and professional mental health staff recruiters mandated to put into effect the recruitment of child and youth mental health professionals in accordance with the youth mental health and suicide prevention human resource plan;

iii. The youth mental health and suicide prevention human resource plan must be developed in tandem with and as an aspect of the Provincial Action Plan for Child and Youth Mental Health and Suicide Prevention and it should establish measurable benchmarks and indicators to monitor our progress as a Province, through ISD and other measures, in eliminating wait-times for child and youth mental health services;

iv. The development of extended mobile mental health crisis units available across the Province on a 24/7 basis to intervene as first responders in situations of mental health crisis when and where they occur;

v. The development with ISD and allied health partners of a Youth Mental Health Prevention and Promotion Strategy, within the overall Action Plan, to include bridging investments that will reduce the need and demand for hospital-based care and subsequently allow resource reallocation to community-based care throughout New Brunswick; this earlier intervention in the community will be more effective when mental health problems present in young people and will equip all children and young people with the wellbeing and wellness training needed to reduce the onset and incidence of mental illness to the greatest extent possible thereby enforcing their right to the enjoyment of the highest attainable standard of health and their right to life, survival and maximum development;

vi. The prevention focus in the above-noted Strategy should address all child and youth prevention needs using social determinants of health and life cycle approaches and looking to the needs of children youth from the moment of gestation and birth preparation forward; the particular needs of vulnerable populations including Indigenous children, LGBTQIS+ children and youth, immigrant and cultural minority youth, official language minority youth and disabled children and youth with disabilities including Foetal Alcohol Spectrum Disorders (FASD) and other neurodevelopmental disorders should be particularly considered and effectively addressed and monitored through the Strategy;

vii. The development of revised hospital staff plans of establishment to ensure the availability of sufficient clinical resources in a distributed capacity across the province, in accordance with the provincial youth mental health human resources plan, to meet local demands for youth suicide prevention and crisis care in youth mental health services, particularly in relation to psychiatry and psychiatric nurse supports in emergency wards and in child and adolescent psychiatry wards and pods;

viii. The development of specialized secure mental health consultation rooms in emergency wards, with sufficient beds and staffing throughout the province to be able to meet crisis demands where and as they present.

Recommendation VIII

It is recommended that the Action Plan for Child and Youth Mental Health and Suicide Prevention implement concrete measures to guarantee the right of New Brunswick children and youth to enjoy the highest attainable standard of health and protect their right to life, survival and maximum development by improving the accessibility of child and youth mental health and suicide prevention services as follows:

i. Improved coordination of all available navigational supports must be prioritized so that every door a child or youth knocks on to receive mental health and suicide prevention supports becomes the right door; this will require sustained investment in favour of informational accessibility, to maintain and expand The Link Program while better integrating its resources into local ISD child and youth teams, and building upon these local collaborations to improve and keep current 211 and 811 services as well as networking with and relying upon the navigation supports of other emergency supports such as Kids Help Phone, Strongest Families and community intervention specialists such as ACCESS Open Minds sites, Social Pediatrics clinics, Child Advocacy Centres, local CMHA chapters, Atlantic Wellness, etc.

ii. Financial accessibility of youth mental health services and suicide prevention services must be addressed by: expanding free counselling services along the model of Atlantic Wellness Centre; expanding the coverage of employee benefit programs to routinely offer up to twelve sessions of psychotherapy or counselling rather than six; develop a provincial plan to gradually expand the scope of provincial medicare coverage to mental health counselling or psychotherapy when prescribed by an attending physician beginning with children and extending to young people up to 30 years of age; and ensuring the universal scope and reach of ISD supports and services to ensure that Child and Youth teams support tertiary complex needs youth as well as interventions with any child or youth presenting with mental health symptoms and primary prevention services aimed at all children and young people;

iii. Emergency departments should all have expanded hours of ER psychiatric nurses and social work supports to deal with any mental health emergencies when and as they present rather than treating mental health crises as emergencies that can wait;

iv. The guarantee of accessibility to these health services in New Brunswick has to be predicated upon the equal access to quality services in both official languages, without exception; increased investment is required to guarantee equal access to mental health services for New Brunswick youth from the francophone minority community across the province, as well as to anglophone minorities where they exist;

v. Rural communities and vulnerable population sectors including First Nations children and youth on and off reserve, immigrant youth, LGBTQIS+ youth, child victims of abuse and sexual trauma, children and youth with disabilities or mental disorders – including youth with FASD, youth with eating disorders and children with autism spectrum disorders should all benefit from expanded service options to make youth mental health and suicide prevention services more directly accessible to them in culturally safe, non-discriminatory, non-stigmatizing environments, including through the provision of transportation supports to access these services and the expanded use of virtual health and mobile health services to connect them with care.

Recommendation IX

It is recommended that the Provincial Government renew its commitment to providing acceptable child and youth mental health and suicide prevention services, both in relation to cultural safety and in relation to medical ethics and health practice standards, to all children and young persons in New Brunswick without discrimination through the adoption of effective measures in the Action Plan for Child and Youth Mental Health and Suicide prevention, as follows:

i. The Department of Health and Health Authorities need to take effective measures to reinforce the delivery of adapted and specialized care for child, adolescent and young adult patients in all mental health care settings. Policies and practices need to be adapted to ensure that children and young people receive care and intervention that is consistent with their rights, their needs and their stage of development in life;

ii. All regional hospitals must have the ability to admit child and youth psychiatry patients in specialized units that are adapted to the level of risks they present as well as to their developmental needs and preferring placement in pediatric care over psychiatric care whenever appropriate;

iii. Protocols and practice standards in emergency rooms should be revised to ensure that: all mental health patients presenting at emergency are triaged in accordance with a validated mental health triage assessment tool and that child and youth patients are treated in relative order of priority; child and youth mental health patients presenting at emergency should all receive a formal suicide risk assessment using a validated screening process administered by a trained mental health clinician; practice standards requiring the avoidance of "No suicide, no harm contracts" with child and youth mental health patients should be stringently enforced; all staff are trained in relation to the risks of suicidality in adolescence and young adulthood, on how to intervene effectively and empathetically and that quality assurance mechanisms are enforced to ensure that discriminatory, derogatory, racist or inappropriate staff/patient interventions are reported, addressed and eradicated; and that upon discharge from the emergency department, each suicidal patient and their family is given the opportunity to create with a properly trained clinician a safety plan developed in accordance with validated tools such as the National Suicide Prevention Centre's Patient Safety Plan template that clearly outlines patient-specific: triggers, coping strategies, people to call/ask for help, crisis plan and helping resources, ways to keep the environment safe (remove means of suicide), and offers the patient reassurance that recovery is possible provides them with a safety plan that leads to that recovery;

iv. Community Mental Health Standards should be revised to better align with ISD, distinguish between child and youth mental health patients and adult patients and implement connection to care standards that favour same day connections to care and ensure no delays greater than 3 to 5 business days for those connections for child and youth patients;

v. All child and youth mental health services, whether in community or in hospital settings, should undertake internal services reviews to ensure that their services are culturally and medically acceptable for all their client groups having particular regard to vulnerable populations including FASD children and youth, children and youth with other neurodevelopmental delays or disabilities, immigrant and refugee children and youth, official language minorities, indigenous minorities, victims of trauma and neglect, including victims of sexual abuse and all forms of gender based violence.

Recommendation X

It is recommended that the Government of New Brunswick take early and effective steps to improve the quality of services in child and youth mental health and suicide prevention in full implementation of the right to life and right to health, as follows:

i. Hospitals should implement in their systems of continuous improvement and quality assurance regular child and youth mental health and suicide prevention updates to review existing protocols and practices and discuss cases and emergent practices in all appropriate forum, including Emergency Department meetings, Quality assurance meetings, nursing staff and physician staff meetings, etc. ; the development of new protocols or changes to existing ones must be clearly communicated to all affected staff and ensure that representatives from all teams are involved in any decision-making regarding changing or developing protocols that relate to their work;

ii. The recommendations for compassionate Caring Crisis Care in the Advocate's Interim report A Matter of Life and Death, should be extended to offer the same training and professional development programs to non-crisis care mental health services staff and frontline staff in child and youth serving departments and agencies; the training programs provided should integrate trauma informed care and child rights based approaches and include tailored interventions for vulnerable population groups;

iii. Social workers in schools, community and in hospital settings should be also be trained, instructed and equipped to assist with the response and supports to child and youth clients who present with suicidal thoughts or behaviour;

iv. Personal wellness classes need to be integrated as a mandatory part of the curriculum at each grade level, with measurable outcomes.

v. School curriculum needs to be enhanced so that young people receive mental health fitness training to be able to better address their own mental health needs but also be able to identify, address and respond effectively to peers who reach out for support or display a need for support; the training should also focus on how to avoid and address stigmatizing or discriminatory comments or behaviours by others;

vi. School curriculum and extra-curricular programming also needs to be reviewed in order to proactively develop resiliency factors among children and youth, starting in early years education and continuing throughout K-12 by promoting preventative, welcoming and thriving environments for learning as a wellness support; positive mental health strategies should be incorporated into all school plans and carefully monitored;

vii. Bachelor of education programs, social work programs, and programs in law faculties, medical faculties, police academies and nursing schools should be revised to ensure that all new professionals working with children and youth receive mandatory training in trauma informed care, social and emotional learning, child rights based approaches, youth mental health literacy and suicide ASIST training; Professionals already in these fields should receive mandatory in-service training and follow up evaluations to verify their competencies in these areas;

viii. The ISD Child and youth teams should implement quality assurance mechanisms across their services, including a revised uniform school-based youth mental health screening tool that is culturally safe and child rights informed to ensure that children and youth seeking to access care are properly triaged at the school level and that all pupils receive the timely interventions and supports they need to be ready to learn.

Recommendation XI

It is recommended that the Government of New Brunswick take early and proactive steps to significantly increase its investment in youth prevention and promotion programming to address youth mental health challenges and suicidality; these measures should include evidence informed school based and community-based programs targeting all population groups, including children and young people of all ages and should be tracked through the Secretariat's quality assurance process and budget for children and youth process to monitor year over year investment and outcomes from these upstream investments.

It is recommended that the Province of New Brunswick jointly with the Advocate's office, the Department of Health, the Coroner's Office, the Child Death Review Committee and all relevant stakeholders develop within the 2021-22 fiscal year a provincial youth suicide prevention strategy for the 2022-2025 three-year cycle, to be renewed in five-year cycles thereafter.

It is recommended that the Government commission a further study into the quality of family life for children and young people aimed at addressing the problem of toxic stress within families and its impact on youth resilience, achievement and mental health.

Recommendation XII

It is recommended that the Government of New Brunswick take effective and immediate measures, upon the direction and advice of the New Brunswick Health Council and the Child and Youth Advocate's Office, to improve quality assurance and continuous improvement in the field of youth suicide prevention and mental health services by investing in research, data collection and data monitoring efforts as follows:

i. The New Brunswick Health Research Foundation, in consultation with the Department of Health, regional health authorities, university research offices and the Advocate's office should develop a provincial plan to nurture and advance child right based approaches for child and youth health and child and youth mental health and suicide prevention in New Brunswick over the next ten years; consideration should be given to the development of New Brunswick medical faculties and of a New Brunswick Children's hospital as part of this plan;

ii. The Chaire de recherche en santé mentale des enfants et des jeunes (CRISMEJ) established at UdeM in 2014, should be extended for a further ten years from 2026 to 2036; a research chair at UNB should also be established in youth suicide prevention and/or in indigenous youth mental health through seed funding provided by the Province; the New Brunswick Health Research Foundation in collaboration with the Advocate's office should develop means to network the conversations between researchers affiliated with such research nodes and clinicians, policy-makers and practitioners in the field through newsletters, seminars, conference and regular network calls and events;

iii. Additional research chairs at Mount Allison, UNBSJ and St-Thomas university could be pursued as well, including a Canada Research Chair in best practices in Child Welfare as suggested by the STU School of Social Work;

iv. Ongoing program evaluation and policy reform and renewed evaluation has to be built in to all child and youth service interventions delivered or funded by the Province of New Brunswick; evaluation funding should prioritize implementation of recognized best practices being tested in New Brunswick including, social pediatrics in community pilots, child advocacy centres, the CMHA's Bounce-Back program for community-based Cognitive Behavioural Therapy (CBT) sessions, the Canadian Mental Health Commission's Roots of Hope initiative, etc.; improved indicators for child and youth mental health need to be developed and monitored;

vi. As the Province moves into the recovery phase of the COVID-19 pandemic, data collection and research initiatives should continue to target research in relation to the COVID-19 impacts on children and youth to assist with their full recovery and address all impacts from the disruption of their education, to their experience of grief, loss and health insecurity, as well as the impacts of social isolation and the public health measures required to combat the spread of infection.

Appendix II : Advisory Board Members

Stakeholder Advisory Council

Co-Chairs: Graydon Nicholas and Léo-Paul Pinet

Members:

- John Sharpe
- Hilary Cartwright
- Mark Wies
- Barbara Whitenect
- Michael Johnston
- Jeffrey LeBlanc
- Bruce MacPherson
- Darren Oakes
- Robert Eckstein
- Vickie Plourde
- Carole Gallant
- Eva Sock
- Roxanne Sappier
- Katina Russell (Feggos)
- Brigitte Dandenault
- Rebecca Clark-Wright

Youth Advisory Council

Co-Chairs: Sue Duguay and Stacie Smith

Members:

- Gracie Lemoine
- John Aidemouni
- Nadia Woodward
- Cassaundra Eisner
- Dust Murphy
- Marilou Landry
- Carlovsky Bellefleur
- Mariah Deleavey
- Neila Selouani
- Maude Sonier
- Maude Levesque
- Sarah Dana
- Myriam Cormier
- Zoé Bourgeois
- Camden Mazerolle

First Nations Advisory Council

Co-chairs: Roxanne Sappier and Natasha Sock

Members:

- Noel Milliea
- Imelda Perley
- Edward Perley
- Hon. Graydon Nicholas
- Ron Brun
- Michael Batchelor
- Mariah Deleavey
- Andrew Dutcher
- Shelley Francis
- David Knockwood
- Brenda Parks
- Rena Solomon
- Dean Vicaire
- Patricia Ward

Provincial Representatives:

- Carole Gallant
- Jerry Clarke
- Kelly O'Neil Morin
- Annie Pellerin

Appendix III : Review Team CYA Staff

- Norman Bossé, Child and Youth Advocate
- Christian Whalen, Deputy Advocate and Lead Investigator
- Gavin Kotze, Director of Systemic Advocacy
- Mélanie Leblanc, Clinical Director, Lead Respondent
- Wendy Cartwright, Coordinator of Systemic Investigations, Lead Investigator for the Lexi Daken Review
- Jessica Forbes, Individual Case Delegate, Co-lead Public Consultation
- Amélie Brutinel, Education and Outreach Coordinator, Co-lead Public Consultation
- Heidi Cyr, Communications Director
- Michelle Lepage, Individual Case Delegate, First Nations Advisory Council Liaison
- Juliette Babineau Moore, Office Manager
- Chelsy Dutcher, Individual Case Delegate, Public Consultation and Listening Tour Coordinator
- Timothy Roberts, Researcher
- Alexandra Dejong, Researcher

Additional Staff Members

- Ken Ross, Project Consultant
- Claude Allard, Research Consultant
- Olivia Frigault, Researcher"
- Dana Richardson, BSW Students in practice placement
- Britany Stewart, BSW Students in practice placement
- Kelsi Pellerin, BSW Students in practice placement

Appendix IV – List of consultations, witnesses and submissions

Provincial Public Consultation Tour with the Advocate (Online):

- Greater Moncton : Tuesday, May 18th, 2021
- Acadian Peninsula : Thursday, May 20th, 2021
- Edmundston : Tuesday, May 25th, 2021
- Upper River Valley : Friday, May 28th, 2021
- Bathurst, Campbelton, Miramichi : Monday, May 31st, 2021
- Chartlotte County : Tuesday, June 1st, 2021
- Mi'gmaq Communities : Thursday, June 3rd, 2021
- Fredericton : Friday, June 4th, 2021
- Saint John : Monday, June 7th, 2021
- Wolastoqey Communities : Tuesday, June 8th, 2021

Experts consulted as part of the Day of Dialogue with Experts and Advisory Board:

- Michael Ungar, Ph.D, Canada Research Chair in Child, Family and Community Resilience / Director, Resilience Research Centre / Scientific Director, Child and Youth Refugee Research Coalition, Dalhousie University
- Dr. Carol Hopkins, Executive Director of Thunderbird Partnership Foundation
- Michael Ungar, Canada Research Chair in Child, Family and Community Resilience / Director, Resilience Research Centre / Scientific Director, Child and Youth Refugee Research Coalition, Dalhousie University

- Professor Patrick McGorry, Professor of Youth Mental Health at the University of Melbourne and Director of Orygen Youth Health and Orygen Youth Health Research Centre in Victoria, Australia
- Dr. William Morrison, Educational Psychology, Faculty of Education, University of New Brunswick, CoExecutive Director of the Health and Education Research Group, and Licensed Psychologist (CPNB)
- Dr. Brenda Restoule, Registered Clinical Psychologist (ON) and CEO, First Peoples Wellness Circle
- Dr. Elaine Deschênes, Pediatrician, Vitalité Health Network
- Dr. Delphine Collin-Vézina, Director of the McGill Centre for Research on Children and Families (CRCF) and Professor in the McGill School of Social Work, Canada.
- Dr. Srividya Iyer, Psychologist, Researcher at the Douglas Hospital Research CentreScientific-Clinical, and Director of ACCESS Open Minds
- Caroline Tait, Professor at the University of Saskatchewan and medical anthropologist

Formal Submissions received by the Child and Youth Advocate Office in response to the Review:

- Comité parental d'appui à l'école, École Sainte-Anne - May 30, 2021
- Canadian Union of Public Employees (CUPE) - May 31, 2021
- New Brunswick Association of Social Workers (NBASW) - June, 2021
- St.Thomas University, School of Social Work - June 24, 2021
- New Brunswick Medical Society - June 25, 2021
- College of Psychologists of New Brunswick (CPNB) - June 28, 2021
- Indigenous Women of the Wabanaki Territories - July 7, 2021
- Han Martins Associates (HMA)
- Bob Eckstein, Asst. Professor, St. Thomas University Bachelor of Social Work Program
- Fédération des jeunes francophones du Nouveau-Brunswick (FJFNB
- Centre de Bénévolat de la Péninsule Acadienne (CBPA) Inc.

Appendix V : First Nations Advisory Council Report

Click here to read the report.

Appendix VI : Suicide, Mental Health and COVID-19 Impacts Background Paper

Document accessible online via the Child and Youth's Advocate website : https://www.cyanb.ca/home

Appendix VII : Recruitment and Retention background paper

Document accessible online via the Child and Youth's Advocate website : https://www.cyanb.ca/home

Endnotes

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