New Brunswick Child & Youth Advocate

Défenseur des enfants et des jeunes du Nouveau-Brunswick

REPORT TO THE LEGISLATIVE ASSEMBLY

An Implementation Report on the Advocate's Youth Mental Health & Suicide Prevention Reports

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What Is This Update?

It is a common lament in public policy that many reports are written; far fewer are followed up and implemented. Too often, there is a flurry of discussion when a report arrives and then it is relegated to the shadows, occasionally referenced with regret when the same problems reoccur.

The role of the Child & Youth Advocate is to act as an officer of the Legislative Assembly. Our office's charge from the Assembly is to provide information so that the legislative branch can hold the executive branch accountable. Providing reports and recommendations is one way to do that. Informing Members of the Legislative Assembly of the status of those recommendations is another way to meet our mandate.

As such, the Child & Youth Advocate is starting a new process of recommendation monitoring. Each report will set a reporting cycle and the Departments will be asked to provide updates on progress through the Advocate's authority under Section 21 of the *Child, Youth and Senior Advocate Act*. Those departmental responses will be compiled regularly in raw form.

This year the Advocate's Office carried out a jurisdictional review of recommendation monitoring processes within New Brunswick, across Canada and beyond. In April 2022 we shared our new recommendations monitoring tools with government departments for the first time. The first reports back from respondent departments have now been received, within the time frames we set out, in late August and September of this year. The process is a thorough one, and our ability to apply it to other reports will depend upon future resources.

Based upon this detailed departmental reporting, the Advocate is able to provide an update to the Legislative Assembly and, through that body, to the public. This process serves two purposes. First, it ensures that recommendations are addressed and there is accountability for how the executive branch of government follows up on issues affecting children and seniors. Second, it allows for reports that may be extensive to be broken down into their most pressing tasks. In this way, reports remain current even as some ideas get adopted and new events occur.

Of course, the process also allows for departments to partially implement, amend, or even reject recommendations. The role of the Advocate is to ensure that issues facing vulnerable populations are fully heard so that elected officials can fully debate them, and that the public can judge if the right thing has been done. If recommendations are rejected, that is part of the process – as long as the Legislative Assembly is informed.

At the end of each of these legislative updates, the Advocate will highlight the most pressing issues and cite the areas which will be followed up in the next update. In doing this, it is our hope that we can provide decision-makers with a sense of priority actions and the most urgent issues.

Ideally, this new process will provide the public – and the children, youth, and seniors whose issues are our concern – confidence that reports are followed up and that the debate around them is meaningful. For the first "legislative update" under this new process, the Advocate has selected a report that is compelling and timely, given recent discussion around our health care and emergency response systems. This first legislative update will focus upon youth mental health and the system that supports young people struggling.

An Urgent Charge: The Background To This Report

On February 18, 2021, sixteen-year-old Lexi Daken walked into the emergency department at the Dr. Everett Chalmers Hospital in Fredericton. Her school guidance counselor was with her, having noticed Lexi struggling and having stayed with her to make sure that she got help. Her father waited anxiously outside due to pandemic restrictions. Lexi waited hours to see someone. She clearly expressed that she was struggling and experiencing suicidal ideation, only to be asked repeatedly if she could go home and stay safe rather than see a psychiatrist. That night, she returned home having not seen psychiatric staff or been assessed for suicide risk. A fax went out the next morning for a referral to a psychiatrist. That follow-up did not occur. Lexi's next, and final, contact with the health care system happened in the early hours of February 24, 2021, when she was brought back to the same hospital following a suicide attempt. That morning, Lexi died.

Lexi's story rightly struck a chord. To read her story is to be haunted by all of the roads not taken. This was not a case where a young person slips away with only subtle warning signs that are clear only in hindsight. She repeatedly called out for help and warned caregivers how dire her situation was. She had caring adults around her who listened and tried to help. She exhibited numerous signs that are known to be warnings. She had all the tools to navigate the system that a young person could have had. For all this, we lost Lexi even as she and those who loved her were crying out for attention.

Soon after, then-Advocate Norman Bossé announced that he would be investigating Lexi's story, and through her story, that he would look at New Brunswick's mental health system for young people. The report that resulted, *The Best We Have To Offer*, was released in September, 2021. It provided 12 recommendations covering a number of areas of our mental health system. Taken together with two previous reports – the interim report *A Matter of Life and Death* and the First Nations-focused *No Child Left Behind*, a picture emerged of a mental health system that had significant work to do to provide prevention, detection, treatment and urgent responses to young people struggling with mental health issues. Even though the youth suicide rate climbed through the previous decade, the mental health system that Lexi – and many young people like her – turned to had significant gaps.

Because of the urgency of this issue – surely, there can be no charge more vital to a society than protecting its children from harm – *The Best We Have To Offer* and its companion reports are the first ones which we have put into our report monitoring process. It is the Advocate's intention, resources pending, to continue reporting twice a year in order to ensure that the issue of youth mental health does not get lost in broader discussions around our health care system.

The recommendations in *The Best We Have To Offer* and its companion reports were developed as a result of thorough investigation and broad consultations across the province reaching well over 4000 participants and overseen by a representative Advisory Board of government, community, academic, First Nations and Youth stakeholders. New Brunswick youth with lived experience in mental health service sectors and their families were heard, as they should be. Several recommendations within the report invite government to ensure that children and young people are part of the process of change. That is their right.

Preliminary Question: Was There A Change In Government's Behaviour?

Before getting into specifics, the Advocate made two general inquiries to see if we could assure New Brunswickers that there was some effort on government's part to truly respond to the reports. If the process is taken seriously, we posited, there should have been some change in the usual pace of funding mental health services and some clear deviation from the plans government was already implementing.

We were encouraged to see that in both cases, there was some positive change in government's behaviour. We tracked twenty years of funding for mental care services. The average rate of increase to mental health services was approximately 3.6%. In the first budget after *The Best We Have To Offer* and the tragedy that led to it, the increase was 7.9%. This was not the largest increase on record – in 2009, the government of the day backed up its transition to community-based services with a double digit increase – but doubling the usual rate of increase is not indifference. We will explore in this report if it was sufficient given the problems that accumulated, but there was a change in focus. Mental health became more important in the budget priority list.

In addition to detailed responses from the Department of Health in our recommendations implementation guide we received a letter from the Deputy Minister of Health on August 26th which enumerated the many positive developments in improved youth mental health services and suicide prevention since February 2021. It is indeed encouraging to see nearly $7 million in new investments for addictions and mental health; $380,000 to maintain services in existing Access Open Minds youth mental health safe spaces in Elsipogtog and the Acadian peninsula; new funding for expanded services in social pediatrics hubs and walk-in mental health supports through Atlantic

Wellness; new funding for the FASD (Fetal alcohol spectrum disorder) Centre of Excellence and increased resourcing and training of Clinical supports to Child and Youth teams and emergency departments to support youth mental health services. These were all recommended by the Advocate, and are all welcome developments.

As well, we wanted to make sure that government did not simply repackage what it was already doing. We tracked the mental health-based planks of the Department's planning documents and we did find that there were significant changes in the number and content of strategic goals. In strategic plans published before and after the report, there were only three recurring goals and a dozen new ones. This is in addition to the government's adoption of the interim recommendations in *A Matter of Life and Death*.

One area where we did not see as clear a change in behaviour was in First Nations-based services and, in particular, the follow-up to the calls to action in *No Child Left Behind*. There has been action there as we shall examine later in this report. However, the number of new directives and strategic goals was quite minimal, and inconsistent with the urgency of this issue in First Nations communities.

As will be detailed in this report, we are not sure that the sum of the individual steps taken yet amounts to the kind of strategic, co-ordinated change that the Advocate recommended. We will explore, in this update, the kind of steps needed to reassure us that there is truly a plan for a province-wide change in mental health services for youth.

That said, we want to assure the public that this process can and does matter. Just as there were significant amendments to child protection legislation after this office released its systemic reports in that area, the events around *The Best We Have To Offer* did measurably change the focus on mental health in a financial and strategic sense. Now, we will see if the increase in money and attention will be enough to improve outcomes for children.

The Focus Of This First Monitoring Report

In this report, we have placed the focus on the lead department for implementing our recommendations – the Department of Health. We have asked the Department to provide us with actions that correspond with each action item in the three reports. The responses to over 70 action items have since been reviewed and the Department was asked to provide follow-up information in response to fifteen areas of inquiry provided by the Advocate. We can report that the co-operation of the Department has been timely in this regard.

In preparing for this summary, we have tried to keep returning to a central, critical question – **would things be different today?** If Lexi Daken, or one of the many young people whose stories share similarities with hers – went looking for help, have we improved the odds that help will arrive? To aid Members in understanding that question, we can place our recommendations into some broad categories and identify the most urgent actions that should be achievable in the first year. Our expectation is that by April of 2023 we should be able to see further progress, particularly in relation to priority areas identified in this legislative update and recommendations monitoring report.

THEME ONE: TIMELY ACCESS TO CARE

In *The Best We Have To Offer*, this theme corresponds to the following recommendations:

Recommendation 7: There needs to be enough professionals available so that children can be seen promptly, and that proper responses and treatment can be provided.

Recommendation 8: There needs to be easy entry points to care so that whoever they are, wherever they live and wherever they enter the system, children with mental health needs are guided to the right care.

Recommendation 9: People in the system should be expected to be able to communicate with children needing mental health care in a way that is child-friendly and culturally sensitive, and both expectations and training should reflect this goal.

Recommendation 10: The health and education systems should have standards and processes in place which are consistent with best and emerging practices in child mental health.

Our one-year expectations: There should be a credible recruitment plan with proper benchmarks established for needed numbers of mental health professionals. Training and improved knowledge transfer protocols should be taking place and the issue of youth mental health should be visible in government's response to current ER and emergency response issues. Training of front-line workers should be underway and practice standards should be evolving to the point that best practices are identified and

documented. Treatment options outside urgent response should be expanded and a clear, credible plan should be in place.

THEME TWO: COMMUNITY SUPPORTS FOR TIMELY PREVENTION AND DETECTION

Emergency services often face pressures when there are failures around community-based prevention. Special attention needs to be paid to the toolkits which peers, families, educators and communities have to provide detection and support to young people. This is vitally important in First Nations communities, where culturally-safe and trauma-informed help is needed to combat a genuine crisis, in which the youth suicide rate is exponentially higher than the provincial average.

Recommendation 2: Community-based groups that offer prevention, support and networks that detect mental health challenges early should attract investment.

Recommendation 4: The acute problem of youth suicide and mental health crises among First Nations youth demand that we empower and fund communities to provide family, cultural and educational support to young people.

Recommendation 6: There should be avenues for young people themselves to tell us what they need and what they see as pressures for their peers.

Recommendation 11: Public and peer education in warning signs and resources will be essential for reaching young people who need help and often do not self-report.

Our one-year expectations: Especially during a pandemic, there should be signs of investment in peer networks and school/community programming. A new plan for youth mental health and addictions and suicide prevention is established to guide subsequent reforms. A clearly-identified point person and department on First Nations issues should be appointed and provided with a mandate and resources. Planning for youth engagement and peer training should be underway. Community partners should be identified, and their roles defined, with clear funding asks being prepared for the upcoming budget cycle.

THEME THREE: GOVERNANCE THAT ADVANCES CHILD RIGHTS, NOT GOVERNMENT SILOS

This theme recurs in numerous reports, and for good reason. Lexi's story is all the more haunting for the missed referrals and absent follow-up at critical moments.

Recommendation 1: Integrated Service Delivery (ISD) needs a minister and secretariat with responsibility and authority to ensure that services meet the child's needs regardless of formal department responsibility.

Recommendation 3: The government should explicitly hold itself to the goal of meeting the child's rights to life, security, and health, with measurements and dispute-resolution mechanisms that advance them.

Recommendation 5: Government needs to recommit to Integrated Service Delivery and that expectation needs to be communicated across all departments.

Recommendation 12: Data tracking, reporting and improvement should be in place for children's mental health.

Our one-year expectation: There should be a review of the complex case protocol and expanded use of integrated teams. The runway to integrated planning for children with acute mental health needs should be made simpler and routine, with barriers identified and a plan in place to eradicate them. Clear responsibility and accountability measures should exist at the cabinet and bureaucratic levels.

A Final Word On The Process

In preparing this update, we have been well aware that the challenges identified in our reports (and in the government's own health plans) are not ones which will be met in one year. If one could simply pass a law that no child would come to harm, we are certain that every Member would support it and it would sail speedily through the Assembly. Indeed, our own recommendations would take a multiyear effort to achieve. However, we have attempted in this report to set reasonable benchmarks for progress and to leave room for departments to find alternate ways of achieving the results we want to see. No report, even one as thorough as *The Best We Have To Offer*, can anticipate every development and every hurdle that will be encountered. We have tried, in launching this process, to leave room for dialogue between an Advocate charged with pushing for needed change and the departments charged with actually delivering it.

That said, we expect to see a sense of urgency. Lexi's story haunts us now as it did then. If it were only one story, with its missed opportunities and tragic delays, it would still call us to change. We know that it is not one story. It echoes in the journeys of struggling young people and the anxious families who cry out for someone to listen and to act. Our new process of monitoring recommendations is our way of saying to the system that things must really change, that we cannot become so numbed by the rhythm of memos and meetings that we forget how urgent the needs are, how high the stakes are. This is our attempt to give elected officials and the public the tools to join in our call for urgency. We hope it will be useful – and used.

Theme One: Access to the Right Care at the Right Time

There are three levels to mental health care, broadly speaking. The first is one that affects all of us, which is access to prevention, advice, and support in managing our mental health. The third is used the least often but can be the most critical, which is crisis response when there is a critical event putting someone at risk of serious harm. Our reports found urgent improvements needed in both those areas.

The second level of mental health care is the one where improvement is so elusive, because it is so profoundly underdeveloped that sometimes it doesn't even enter into the equation enough to make a mistake. It is simply absent in too many cases. That is the middle level of treatment, where a young person with mental health needs can get the timely, predictable and accessible care that keeps a problem from becoming a terrifying crisis.

It is important to understand the three levels and to avoid mistaking progress in one area for progress in the others. There is a tendency in our policy approach to mental health to focus on the first level because it is the simplest and most affordable level to change. One can get lost in a dizzying array of web sites, hotlines, discussion forums, self-assessments and personal mental health online tools. They are almost all valid and all important. But they are not treatment, and they are not a crisis response.

To draw a parallel to the more traditional (and better established) physical health care system, there is a place for resources on healthy eating, for open spaces for exercise, for community support groups and educational materials on heart-healthy lifestyles. However, if someone comes into an emergency room in severe distress from a possible heart attack, it is decidedly not the time to provide fact sheets on diet and exercise. There is a need for a proper crisis response. And there will be a need for timely follow-up care and primary health care.

Understanding those three levels is important in understanding our analysis of how government has responded to our recommendations in the last twelve months, because it is important not to mistake a flurry of activity with actual solutions. A bevy of self-help tools are not crisis care. An array of navigation tools are only helpful if there are services to navigate to. And a multiplicity of pilot projects are only meaningful if there is a will to replicate what works at a universal level.

In one of the many mental health reviews in Canada, one young person who had been through the mental health system remarked that there are very few available services between sitting on one's couch and going to the emergency room. This wise young person has captured the challenge in our mental health care systems across Canada. There is simply a lack of timely care between daily management and crisis response. While *The Best We Have To Offer* looks at shortcomings of how we responded to a young person in a crisis that happened, it is just as critical to look at what did not happen between those crises – sustained and timely mental health care that might have prevented the crisis.

In each of the three areas, there are positive steps that we believe are a credit to the work of the Department of Health and are consistent with our recommendations. They should be detailed here because they will make a difference and they should be known and understood by the public.

At the community level, we note reports of investments in community-level organizations. However, we have serious concerns about government's inability to manage these partnerships in a strategic way. As an example, we would note our call for funding for peer support networks such as The Link. Responses from the Health Department suggest that they are in discussions with that organization regarding funding and mission. Yet, the program was cut by $40,000 on the eve of a pandemic and over two years later, even a basic statement of what will happen is still elusive. Spokespeople for the Departments of Education and Social Development have responded with a flurry of bureaucratic nonsense, citing unrelated spending increases and dodging questions.

The Advocate wishes to be clear. Especially coming out of the isolation of a pandemic period, peer-level navigation advice and awareness on warning signs will lead to timely interventions that save lives. It is frankly embarrassing that three departments with over $5Billion in funding cannot resolve a $40,000 funding issue in two-and-a-half years. It speaks to the systemic problems that plague New Brunswick's partnerships with community organizations – individual funding announcements are trumpeted for public relations value, but if there is any attempt to look for a strategy, a long-term plan, or even basic accountability, organizations trying to provide service get lost in a sea of obfuscation and avoidance. If government has a real plan to provide peer-level support and information that renders the Link unnecessary, let them say so. If not, senior leadership at the three departments needs to get this small issue resolved. They have enough time and money available that the absence of an answer is either deliberate or breathtakingly negligent.

It would be a shame to see our confidence shaken by this example, because at the conceptual stage there are some interesting ideas for community partnerships. We are intrigued by the identification of the Icelandic model – which identifies community indicators such as extracurricular participation and parental engagement which lead to decreases in substance abuse and mental health struggles -- as a basis for community supports and look forward to seeing it linked to funding agreements with community partners. We are seeing a commitment to navigation and information tools such as the *Bridge the Gapp* online tool and new mental health information lines. We are extremely positive about the potential for the social pediatrics model and hope to see active support for building community partnerships to expand this model. However, the fumbling of the Link file makes it hard to know how competently other community partnerships will be managed or developed.

At the primary care level, we believe that the vision articulated by the former Minister of Health for walk-in access to mental health professionals and “One At A Time” counselling access is a sound one and the quick mobilization of One At A Time counselling has been encouraging. We are particularly hopeful about the vision for Youth Wellness Hubs and note the success that British Columbia, Quebec, and Ontario are having in integrating these multi-service sites with emergency services to ensure seamless and prompt follow-up, and the Department seems keenly aware of the importance of this feature in their planning.

In crisis response, there has been significant effort put into training for emergency room staff and developing procedures for knowledge transfer and hand-offs between emergency providers and primary care providers for follow-up care. As a consequence of the additional funding for mental health services, there have been 27.5 new positions added at the RHA level on Child & Youth teams and another 51.3 positions in emergency services. There has been success in filling these positions. As a result, there is a greater likelihood that, as noted in our recommendations, that a young person presenting at an emergency room will have a proper assessment and that the right expertise will be available to the care team. As per our recommendation for more child-friendly approaches, there has been some thought as to emergency room settings and quiet spaces that offer a better environment for young people in crisis. There has been some initial thought to mobile crisis units and 24/7 responses to mental health crises, although the Department acknowledges that staffing has been a challenge which has made the coverage more reliant upon Tele-Health and less predictable than it should be.

These are all changes which deserve to be noted and they are consistent with our recommendations. However, we are left with concerns that these are less than the sum of their parts because a clear plan has not yet emerged for how we get to the system our children deserve.

Gaps In The Response – What Does A Province-Wide Approach Look Like?

The Best We Have To Offer calls for a human resource plan. This will require a change in our mindset. We have gotten so used to shortages that we now acquire as many professionals as we can and then ask what kind of system we can have. We need to start being transparent about what it will take to have the system we need, and then develop a plan to develop the human resources that system will require.

The reason why we make this point is that our mindset in planning for health care positions has never fully recovered from the miscalculations of the 1990s austerity era. Faced with controlling costs while offering a free service, governments began rigidly limiting training of everything from doctors to mental health professionals. Even today, there is a pervasive attitude that it is a great sin to fund university or college spaces without being certain that there will be a dire need for graduates in the employment market. (In fairness to governments of the age, the trend of members of the smaller Generation X suffering through underemployment waiting for Baby Boomers to retire may have also factored into these considerations).

The result has been a mindset in human resource planning that places the needs of the system third, behind fiscal considerations and an obsession with instant employment. We have even heard of students receiving support to attend nursing programs still being required to produce essays explaining how the training will lead to employment – in nursing. The result is a system that still rations training even as tales of desperate shortages fill the headlines. In mental health, the disconnect has grown truly bizarre. We have a mental health system where there are wait times for treatment and an education system where children go unassessed, and we are training less-qualified employees to do the work of psychologists. Psychology remains one of the most popular undergraduate majors, yet in recent years you could count the number of available spaces in doctoral programs in psychology on your fingers, and students are routinely told that there is no point in even considering the career if one's G.P.A. is not above 4.0. (We have great respect for the profession, but somehow doctors, lawyers and every other profession seem to muddle through without screening out graduates quite so aggressively).

We understand financial budgeting will always need to happen; however, we need to establish targets for wait times in urgent cases, mobile crisis intervention and follow-up treatment and be transparent about what staffing levels will be required. Then we can truly have an informed debate about whether the investment is worthwhile or if we are willing to lower our standards. The ethos of constant crisis is making it acceptable not to plan, and that needs to change.

Our office will be launching a focused inquiry under Section 13 of the *Child, Youth and Senior Advocate Act* to look at the integration between Health and the Department of Post-Secondary Education, Training and Labour, and we will be looking for progress in this area in our next recommendation monitoring report on youth mental health.

Also, while we applaud the thinking and effort that has gone into pilot projects, at some point there needs to be a connection between pilot projects and a province-wide plan. Twenty pilot projects do not a provincial system make. The thinking behind wellness hubs, one-at-a-time and walk-in services is solid, even impressive. Details on what is being measured to determine if there will be a provincial model, what timeline is achievable and if the funding and staffing will be there are vague at best. A pilot project without a roll-out plan is not a pilot project – it is a placebo.

We would challenge government to have clear statements of what pilot projects are looking to measure, how they will be replicated, and to make multi-year funding plans consistent with the roll-out of a provincial system. It is all well and good to have an example of a youth wellness hub or a walk-in clinic. However, if we cannot currently fund and staff 24/7 mobile crisis services and there is no plan and budget for a provincial rollout of these new services, we are not sure what is being piloted. We will be looking for that planning in our next update.

Finally, we are pleased to see the development of protocols for when to assess suicide risk, when to consult mental health professionals, how to handle handoffs and knowledge transfers, and other training programs for emergency staff. We are concerned by the fact that these have not yet become policies and regulations with measures to confirm their use. We also urge the Department to continue to evolve training modules to cover common areas of mental health issues, such as eating disorders and sexual identity. There should be a clear training curriculum that can be offered and measured for how many team members have completed the training.

Theme Two: Planning at the Community Level

Similarly, while we applaud the spirit behind the list of community projects getting funded, they are not united by a statement of what services are needed province-wide and what the role of each organization is in meeting that coverage. There is always a risk of, again, piloting a system into incoherence. Peer networks and awareness are excellent, and we should have some sense centrally how complete the coverage is and how uniform the information. Navigation tools are great, but we should be sure that messages are consistent and that there is a clear sense of where to turn for help. Funding should come with clear, documented communication of what services are expected for the funding and some provincial co-ordination should always be clear.

We want to unequivocally applaud the funding of social pediatric programs and encourage the Department to continue these efforts. We also want to note the promise of the Icelandic model and encourage the Department to take note of concerns about equal access of youth to recreation and community programs and begin planning now, likely with the collaboration of the Department of Social Development, to ensure that this model is viewed through the lens of socioeconomic equality and equal access for rural and urban communities.

We would be remiss if we did not make a comment about the urgency of the situation in First Nations communities. The differences in suicide rates and a host of other indicators are unconscionable. Two things need to be done. First, the reported progress in services in Elsipogtog needs to be accompanied by a plan to roll out services in the other 14 First Nations. The problem is too acute to have only one story to tell. Secondly, there needs to be a clear point person identified by government to act as the point for a First Nations mental health plan. We are hearing from leaders in First Nations communities that several departments are each claiming the lead lies elsewhere. This needs to stop, and the process needs to be clarified and activated. One year without even a clear plan to have a plan is unacceptable to us, and the Advocate intends to be persistent on these two very focused and achievable recommendations.

Theme Three: Governance and Integrated Service Delivery

We should start by giving credit where it is due – the decision of the Legislative Assembly to amend the *Child and Youth Well-Being Act* to allow the Minister of Social Development to compel (as opposed to merely request) health and education authorities to participate in planning was potentially one of the most positive developments for integrated service delivery (ISD) in some years. It is rare for a majority Legislature to make substantive amendments to bills in New Brunswick, and that several were made to child protection legislation reflected efforts by all Members to have a review of that bill that was thoughtful, open-minded, and above partisanship. We were encouraged by the fact that issues affecting vulnerable children brought out the best in the system.

We are also seeing signs of a recommitment to ISD through the Department's approach to mental health services for children in care and the ISD Backbone unit, as well as the use of Child & Youth teams. We would encourage the government to keep this momentum going by ensuring that there is automatic integrated planning for several categories of children. In the context of this report, we would urge government to adopt the practice that any child treated for emergency mental health services or receiving a suicide assessment should automatically have an ISD common plan and casefile opened. There should be no time wasted waiting for a cumbersome or unpredictable complex case assessment when this happens.

We would also make an appeal, as we have in past reports, that there be clear cabinet-level responsibility for ISD, even if it is done by clearly empowering one of the ministers of the "big three" social departments.

Finally, we have expressed concern in our follow-up questions in this process that the use of funds provided to government under the 2017 bilateral health agreements has not been clearly reported. Mental health and First Nations programming are both explicitly listed as priority areas in those agreements, and our office has asked several times over the years for an accounting of those funds. We appreciate the commitment of the Department's new leadership to ensure that this request will be met this time, and the Advocate does intend to ensure that it occurs.

Following Up

As already noted, we have prioritized youth mental health as the first set of reports to be put through this new recommendation monitoring process. It is our intention to follow up again in the Spring of 2023, in approximately eight months. We have strived in the preceding three themes to make a clear statement of what we will be looking for in terms of progress by then.

There should be some predictable, accessible service for young people between surfing the web for help and presenting at an Emergency Room, and the areas we have prioritized are the ones which we think are most important in the reports to monitor in the next eight months. For greater certainty, these priority areas are as follows:

- ***Benchmarks and recruiting targets for mental health professionals in a human resource plan that aligns budgets and educational spaces with standards for patient service and response times.***

- ***Clear plans and measurables for the transition from pilot projects to a province-wide response.***

- ***Entrenchment of protocols for risk assessment and knowledge transfer into policy with a framework in place to measure implementation.***

- ***Clear statements of training requirements for emergency staff and team members, including physicians.***

- ***Service agreements, coordinated between all three social departments as part of a provincial plan, for community partnerships and funding grants.***

- ***Definition of community services to be used in the Icelandic Model along with plans to ensure geographic and socioeconomic equity in their availability.***

- ***Appointment of a clear lead in mental health services and suicide prevention for First Nations youth.***

- ***Clear plans for service provision in each of the 15 First Nations.***

- ***Cabinet-level responsibility for Integrated Service Delivery and management of files for children with complex needs.***

- ***Reflection of an Integrated Service Delivery focus in the regulations under the Children's Well-Being Act.***

- ***Automatic initiation of ISD Protocols upon emergency provision of mental health services.***

- ***Proper reporting for use of funds received under federal-provincial agreements for mental health and First Nations health services.***

- ***Multi-year planning and budgeting for walk-in, mobile crisis, and "One At A Time" counselling services aligned to a proper province-wide plan.***

A General Comment on the Healthcare System

We would be remiss if we did not acknowledge that any review of emergency mental health services is taking place in a different, and more concerning, environment than existed a year ago. After all, this process exists in response to a tragedy in which a child sought emergency help and did not get it. We have tried to keep in mind the vital question – **would there be a different outcome today?** There have been actions detailed here that should, in themselves, make the odds better. Not good enough yet, but better. However, the overall situation in our emergency rooms has deteriorated.

It is not the Advocate's practice to make detailed findings on cases that have not been properly reviewed. However, without making specific comments as to what happened in each individual case, it is impossible not to note the uncontested reported events of recent months. We see deaths in waiting areas. We see victims of sexual assault sent home without the attention and support they deserve. We see a discharge so abrupt that the Premier intervenes. And we have to ask, for all the specific actions in mental health services, would the next Lexi Daken walk into an emergency department ready to fully use these tools with the attention, compassion and focus that a child deserves?

The Advocate is very concerned that our health care system is beginning to normalize things that should never be normal. The current situation was not borne of one government, or even one pandemic. There have been warnings that unaddressed issues in emergency-room care, professional recruitment, community care, long-term care, professional regulation – that they had left us one straw away from the breaking point. The straw came. And while we would not flippantly say that the system is broken, the confidence citizens have that they will be cared for if they need urgent care has been shaken. People are scared.

Good people still do good things in our health care system. We are putting pressures on our urgent care system that can lead to a very dark new normal. When it is normal to be understaffed and under-resourced, we normalize the unacceptable. Attention to detail wears thin. Caring people placed in situations where they cannot provide the care they know is right begin to get numb and detached as a coping mechanism. Compassion starts to decline. Patients become afraid to speak up or ask questions,

even when those interventions might provide needed information, because they are so afraid to be denied the scarce attention they get. Managers become afraid to question any failing, because we cannot afford to alienate any of our scarce professionals. Risks grow until soon; we aren't even shocked anymore when someone looks for help and it isn't there.

And once we can't be shocked, we lose the capacity to do better.

Our office does not have the resources to be the ultimate arbiter of health reform. However, we are charged with speaking for groups who are vulnerable to breakdowns in government services, and if we do not have all the answers, we can urge the government to look for them. As we continue to recover from the current pandemic, we have to remain alert to the strains it has placed on already fragile systems of health and social services.

We are aware that there is a surplus. We are not economists or tax experts, but we do know that health care is a core function of government. If we are going to pass laws blocking people from going outside the system (for good reasons of equality and efficiency), then the system we require them to rely upon must work. Even if the changes are temporary rather than structural, we urge government to make this a first priority. Get proper spaces in long-term and community care to ease the pressure on hospitals. Fund primary care providers to have offices open outside of traditional hours or to see orphan patients – even at a temporary premium. Empower and staff the patient advocates to have non-medical personnel who can make sure that there is communication and attention when someone seems to be slipping through the cracks. Look at every function from prescribing to advising and ask if someone other than a doctor can do it.

While the federal government does not have to listen to the New Brunswick Child Advocate, they have a role here. We note that federal officials are saying that new funding is awaiting more data. While we will always urge the provincial government to accept accountability and reporting measures to make a funding deal work, we would also urge the federal government to heed Bob Dylan's admonition that you don't need a weatherman to know which way the wind blows. There is a crisis, and all the same comments we made about New Brunswick' surplus and interim measures apply to the urgency the federal government should feel.

In the context of youth mental health, this is even more acute. The federal government has confirmed that in the months ahead, they will follow through with their plans to make medically assisted dying available for those suffering from mental illness alone, and that there will be an extension of this option for "mature minors".

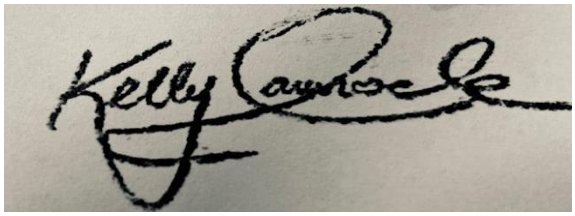
It would be a tragedy if the federal government acted with more efficiency regulating death from mental illness than it did in treating mental illness. Some might even call it a moral failing.

No less an authority than New Brunswick's own Graydon Nicholas has noted that there have been requests for medically assisted deaths from people citing a lack of government services, like housing and treatment, in their requests. We have been warned of the risk of allowing the right to manage one's death to provide governments with a moral loophole to do less than they could to alleviate the suffering of the living. When this risk is imported into the world of young people with mental health issues, there is the potential for a moral catastrophe.

In short, the situation calls for urgency in prevention, treatment, and compassion. We urge all those elected to grasp the urgency of the moment. Because we know the story of Lexi Daken, we cannot ever again say that we did not know the stakes.

Our office cannot make those decisions or force anyone to act. We can make sure that all those with the power to help – and every citizen willing to lend their voice to the charge – knows the stakes. We will continue to report on this issue with the urgency it deserves. We would dearly love for those reports to form a story of New Brunswick's capacity to change.

SUBMITTED TO THE LEGISLATIVE ASSEMBLY this 3rd day of October, 2022



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