Transcript: Navigating the Child and Youth Mental Health Crisis: Challenges and Opportunities

Connected by purpose. Driven by passion. This is Children's Healthcare Canada's SPARK: Conversations podcast series.

Katharine: Welcome to SPARK Conversations, which is **Children's Healthcare Canada's** monthly podcast series. At the crossroads of children's healthcare, system improvement, and leadership, SPARK Conversations is a solution-focused podcast that connects the child and youth health community with system leaders, who tackle wicked problems and discuss ideas to inform the development of innovative and integrated systems serving children and youth. SPARK Conversations is one component of our SPARK Knowledge Mobilization Program. SPARK is the Shared Platform for Advocacy, Research, and Knowledge. I'm Dr. Katharine Smart and today I'm delighted to be speaking with Dr. Javeed Sukhera.

Dr. Javeed Sukhera is the Chair of Psychiatry at the Institute of Living (IOL), and Chief of Psychiatry at Hartford Hospital under the Hartford Healthcare Behavioral Health Network. He is also an Associate Clinical Professor at Yale University's School of Medicine. He joins Hartford Healthcare from London, Ontario, Canada, where he served as Associate Professor of Psychiatry and Pediatrics at the Schulich School of Medicine and Dentistry at Western University and provided clinical consultation to the Child and Adolescent Mental Healthcare Program and Pediatric Chronic Pain Program at London Health Sciences Centre (LHSC). He has held various leadership roles throughout his career including as Senior Designate Physician Lead for Child and Adolescent Psychiatry at London Health Sciences Centre and Academic Director for Global Health Curriculum at the Schulich School of Medicine and Dentistry.

Today's podcast is timely as it relates to a project that is important to Children's Healthcare Canada, our members, and the broader child health community- Inspiring Healthy Futures (IHF). Inspiring Healthy Futures was founded in 2021 by UNICEF Canada, CIHR, Pediatric Chairs of Canada, and Children's Healthcare Canada in response to the UNICEF Report #16 (done in 2020), where Canada ranked a shocking 30th out of 38 wealthy countries in the health and well-being of its children and youth. Inspiring Healthy Futures is a pan-Canadian, cross-sector action that involves 1500 diverse group of youth, parents, service providers, youth serving agencies, cross-sector experts, and researchers,

educators, advocates, policymakers, and many others. The Inspiring Health Futures community will reconvene on October 27 to celebrate the awareness and tangible actions taken in the 3 years since the initiative began to work towards our shared goal of improving outcomes for kids.

Today we are chatting about an extremely important topic – child and youth mental health. Hello Javeed, and welcome to SPARK: Conversations.

Javeed: Hi, thanks so much for having me. I'm really looking forward to a conversation today.

Katharine: So am I. So we've all heard your bio, you are obviously an internationally recognized psychiatrist. You're also an activist and an advocate for trauma informed care and building awareness of implicit bias in medicine. Your research program explores novel approaches to addressing stigma and bias among healthcare professionals. And you've been involved in advocacy and cross sectoral work, policing and community services. So thank you so much for joining us today. And I'm really looking forward to your perspective and learning more about your experience as a leader in pediatric psychiatry. So, as you probably know, I'm sure you're familiar with Children's Healthcare Canada and seen a lot of their social media work, and they're really on a mission to try to right-size children's health systems in Canada. So from your perspective, as a thought leader and educator, a physician and a researcher with extensive experience in pediatric psychiatry, what do you think are the main barriers that are limiting children's access to timely and appropriate mental health services? So that's the first part of my question. And then the second part is, whether you practice in Canada or in the US, have you seen solutions successfully implemented that have increased access to mental health services in a resource constrained environment?

Javeed: So the last three words of your question are the biggest challenge; the resource constrained environment. And I think in my experience, having lived and worked and trained in so many different international settings, when I started my career in Southwestern Ontario, I came back to Canadian healthcare system that I had always held on a pedestal, a system, which there's a considerable amount of pride as there should be; but also a system that I came face-to-face with that simply was not adequately funded. In particular, children's healthcare, children's mental health care is even more disproportionately underfunded. And so in the early years, as I saw the problems in the system, and I worked through our Children's Hospital and through our community to try to make change, the comments that came back were, well, you know, we're not going to change the funding. So we have to figure out how to look at what we've got within our current resources. And we did, we tried. But the reality is, when you're starting from a point of, you know, negative 10, when it comes to how underfunded healthcare is, and how much the promise of the Canada Health Act is not being fulfilled, for young people with mental health issues, it's really difficult to make things better without collective advocacy around right-sizing, some of the resources. That stated, I think another barrier is that our health system in Canada is not a system that is attuned to the amazing return on investment when it comes to early intervention. We know it's not attuned to it, because so much of the funding that we do see given to children's health or children's mental health is often sprinkled in politically, politically popular pilot projects across the country. And it's sprinkled here and there with a big photo op and a press conference, without really recognizing how underfunded the basic operational systems are the people your and my colleagues are working in community settings with young people who are on waitlists that are climbing in terms of length, without anywhere else to go.

In terms of solutions though, which is the second part of your question, I think that going beyond addressing the underfunding, the chronic persistent, and what I would call discriminatory underfunding of children's health, is actually turning to young people and their families and caregivers for disruptive

solutions. That things that I think I've seen work the best are when we co-design solutions and systems of care with young people and with their caregivers. Whether those innovations are things that are after hours, or drop in, or innovations that are infused with technology, or things that fall in the more health promotion and prevention realm. It's when we provide real-time care to kids and young people, meeting them where they're at, when they're in need, that we can actually create magic. And to do that we really have to turn things a little bit upside down when it comes to what's normal.

Katharine: I'm curious, you know, based on your experience in co-designing these systems with youth and their families, what's the thing that you learned that surprised you the most in that process that maybe you weren't expecting?

Javeed: I think actually the question is, what did I have to unlearn most? When I first started my career, my job was to build and integrated services for young adults. And the way that I approached that was really to get out of my office and the tower that I had it in and drive out into community settings and talk to young people where they were at. And they would say things like, I can't believe you came here. You know, we're always told to just come to the hospital, and then we have to pay for parking. And we don't know where we're going. And it's really intimidating. And I would be like, well why would why would we do that? Right? We should be coming out to where you're at. And where you function, why should we expect you or your caregivers to come to the hospital? Or I would hear things like, wow, you know, I've never really met a psychiatrist before. And what I think I had to unlearn was the way that we in healthcare sometimes tend to center ourselves in these conversations. We don't even realize it. But we get to a point where we become tokenistic. Again, we're well intentioned, but we become very tokenistic in our engagement, because we're bound by timelines and grant stipulations or regulatory requirements or legal issues. And I think that when working with, with others, with partners, in all sorts of settings, there has to be a greater degree of humility and patience that isn't always taught to us in healthcare.

Katharine: Absolutely. And I think it's so interesting too right because, as you said the way we're trained, it's also it's always I think, really focuses on sort of centering on the information we need. The way we want to deliver it in our settings, our contexts, where we sort of have the power and control and that idea of sort of flipping it the other direction isn't something I don't think we talk a lot on our training. And like you, I found that my own lived experience of actually practicing medicine has really made me have to challenge some of the assumptions and the things that I was taught and unlearn them. As you said, I think it's a great term. To really be able to meet people where they're at and just have a different idea about what it means to care for people. Because it's not always our way isn't always the best way. So it's, it's wonderful to hear that you've had that similar sort of learning about the unlearning and in your lived experience in medicine as well.

This fall, Children's Healthcare Canada is going to be convening leaders from across the continuum of care to help us understand what improving access to children's mental health services might look like for kids and youth living in Canada. So in that conversation, what would be at the top of the list for you that you think that group should be sure to focus on?

Javeed: I think the top of the list is that mental health care workforce. During my time, over a decade, of being at this point of care, trying to advocate for change; the experience of so many working in children's mental health is a gradual need to extend oneself more and more. Increasing volumes,

increasing emergency hospital presentation, and stagnant numbers of mental health care workers. So this is a workforce that's been neglected. There hasn't been any systematic health human resource planning, there hasn't been any strategic work, to invest in developing the workforce or the sustainability of the workforce. We've seen a lot of attrition. A lot of different disciplines can actually make significantly more money and have significantly more flexibility by working in more of a private PACs practice model in Canada, where we have two-tiered mental health care. And so the people who are left in communities, doing care for people who deserve care, but maybe don't have the means to access it, are exhausted. So I think this workforce has to be one that's invested in. It has to be one that's listened to. I also think that there's a continuum of folks involved in children's mental health. And it's really important to recognize the folks that are doing the work after hours, taking call overnight. And think about how we support those doing the work with some of the most complex and challenging clinical scenarios, that's often in the shadows and goes unrecognized and unrewarded.

Katharine: I think that's so true. And I think your point is so well taken about, we really do have two-tiered access to mental health care, because so many of the services folks needs aren't available under our sort of universal insurance policy. And I think it's important for Canadians to understand that that, and I think particularly in mental health, where children often need, you know, a team of people to meet their needs. And in my experience, often the families are also struggling. And it's not only about the child, but it's also about supporting them in their family, whatever that looks like and supporting those caregivers. And sometimes I feel our systems aren't well designed to see children as part of a family or community. And I think that sometimes makes it hard for us to get people the help they need. I'm curious if you've had that experience as well.

Javeed: I do think that there are a lot of blind spots for us as Canadians. For us to look in the mirror at our system means confronting the fact that maybe it's not as great as we aspire for it to be. And I think that that can be really challenging. It can be really emotionally distressing. But at the same time, we have to you know, I'm a Canadian, I'm not living in Canada right now, but I love Canada. And when you love some something, you tell them the truth. So we have to confront the truth that this promise of Medicare for children and youth has not been fulfilled. The truth that the architects of our system, defined children's mental health is not medically necessary. And that what that results in is access to care requires out of pocket costs, unless there's waitlists for the very limited public available, publicly available things like psychotherapy. So the candid result is that many settings in our country people are waiting years for access to basic medically necessary services. It's a difficult reality to confront. But it's something that has to be named before we can work to make it better. I'm optimistic. I think it can get better. But the reality of what we're facing has to be acknowledged and within the broader healthcare community, I think there also needs to be a radical reckoning with the fact that we've been accepting a status quo up two-tiered care for a very long time.

Katharine: No, I absolutely agree with you. And I think, you know, it also reflects in how we train people who work with children and youth, you know, I think about this a lot as a pediatrician. Now working in the community, I'd say, you know, 80% of my practice is probably now mental health, behavioral medicine. And it was one month of my four years of training to become a pediatrician, you know, so even our training programs, I think, undervalue, and don't recognize what the job actually looks like when you get out into the community. And you know, for many children, of course, accessing a child

psychiatrist is really challenging and for a lot of kids, their access is going to be their family doctor or pediatrician. And I worry that we haven't really recognized the need to make sure that people have the skills to be able to do that work comfortably, competently, and to have confidence that they can make a difference for those kids and youth. What's your experience been like, you know, in terms of collaborating with other types of physicians, either pediatricians or family doctors in terms of delivering care? And do you think that's an important part of how we solve the access issue?

Javeed: I do, I think we're all on the same team. And sadly I think that when you have a resource constrained environment that can lead to a greater degree of stress and a little bit more territorialism. That's also something that often is an elephant in the room when it comes to children's mental health is that there's lots of different disciplines, there's lots of different folks that are different members of the team, that often times sadly become, create an environment where it feels like we're competing against each other. When really, we are all on the same team, we're all on the same team and this young person is at the center of that. So I think the onus is on us all different groups and specialties to remember that we need a lot more of all of us, and the ways in which we relate. There's a lot of ways that we can all be working within our scope of practice, but collectively, sharing the knowledge, the expertise, and some of the work that it takes to help these children and families. My experience has been working in pediatric chronic pain program. Work that I loved, work that's very complex. And we would often say to young people and families, the system that we have got; it sees you in parts and pieces, but we see you as a whole person. And there's tons of people on this team, there's lots of folks, it might be a little scary and a little intimidating. But what we want to do is put all of our heads together and put you at the center, so that you don't have to your tell a million times to a million different people. And we're all going to bring what we can and we're all going to work together because we know that what you're dealing with is complex enough that it will benefit from all of our expertise.

Katharine: Yeah, it's such a great example of a complex problem that really does take a team to solve. And again, that idea of seeing people as whole people and not trying to break them down into body parts to try to solve their problem. I think that's so important. Now I know another big area where you're a huge advocate is around trauma-informed care. And you've really demonstrated a keen interest in quality mental health care services for newcomers and refugee children and youth. Can you tell us a little bit more about what that looks like? And how it might be different or the same two services that we provide routinely?

Javeed: Absolutely. So essentially trauma-informed care is something that's really engendered a lot of interest and proliferation. And there's been a lot more people who've been talking about it. From my perspective, it's really in our community, through the community services sector, through lots of scholars and people work in the area of gender-based violence that I've learned a lot about what trauma-informed care really means, and how it's different from trauma specific or trauma focused services. Trauma focused services are really more clinically oriented around treating symptoms of trauma, whereas trauma-informed care is really a holistic way of reimagining what we do. What's really different about trauma-informed care is that it's not just a buzzword, or you know, a project or something that's popular, it's really a whole scale reimagining of care by considering the humanity of not just the person who's seeking care, but also the person who's delivering care. And it's also explicitly something that has to happen at an individual level, but also at an organizational level. So what this looks like, it really looks like being attuned to individuals within an organization supporting them as part of co-creating change. But also providing them with organizational structures that allow them to do that. In my current role, for example, we know that when we're encountering or working with this kind of complexity, we need to make sure that we support our staff, in being able to have the time to deal with

it. We now know that we need to address and be attuned to vicarious trauma, and emotional labor that staff may be involved in. And when it comes to newcomer, refugee children and youth, I think it goes beyond simply understanding and appreciating the effects of their trauma, to honoring and celebrating their resilience and their joy and their strengths. A lot of the narrative around newcomers to Canada often can push in and lead to a kind of sense of tokenization. But what I've found most enriching in my work with these young people is how much their narrative is one that they get to be the authors on, and how important it is to remind them that they are and should always be in the driver's seat when it comes to how they approach decisions about their care.

Katharine: Thank you for sharing that. That sounds like a wonderful model and I love that kind of flipping things on its head and really looking for what are the strengths that people bring to the table. And how can we help people maximize and optimize those strengths. And I think you're absolutely right, we have lots of examples of different populations that are really inherently resilient and have been through so much and probably have a lot to teach us as well.

As you mentioned, you're now practicing in the US, are there any promising practices or innovative models of care that you've seen there that have inspired you, that might be relevant to us in the Canadian context, in terms of how we deliver services?

Javeed: So this is, I think, a bit of a tricky question. It's a tricky question, because it requires confronting some of the realities of the differences in our systems. I think a challenging conversation for Canadians is often discussing the US system, because Canadians do tend to have somewhat of an allergy to this kind of comparison in some ways. Now, the US is an extreme example of a system that's got many different systems within it. So it's important to recognize that, because there's much more of a local jurisdiction over healthcare, governance costs and organization; what's happening in an American state, like where I am, such as Connecticut, where I've lived before, such as New York, is very different than other American states. Currently, where I live, people will say things to me like, oh, well, how many people are uninsured? The amount of uninsured children where I am is extremely low. In fact, it's probably not vastly far away from the number of uninsured or undocumented kids in an urban setting in Canada. But what I can tell you is that if a young person needs access to quality mental health care, they're probably getting it within a couple of weeks here. Whereas in many settings in Ontario, they were waiting months or years. Why that's happening is because there's just that much more availability of services. And yes, there's an apples to oranges comparison that we shouldn't be doing. But I think one of the things that we have to reckon with in Canada is that there are many examples of developed countries, where people who wouldn't otherwise be able to access care because of cost can access it better than they can in Canada.

Those practices or models really do require deconstructing and understanding how mental health care is funded, how its funded per capita compared to physical health care, and how the mental health care workforce is invested in. Other examples include bringing together primary care teams, so we have a surplus in my new organization, where we provide, again, state funded, publicly funded consultation to community pediatricians as part of our work. People can access on call child and adolescent psychiatrist at all times in pediatric practices and have very timely pathways to access consultation.

Katharine: That's a great example I think of how we can support our teams and each other to allow you know, more people to be able to do the work, right? I think often, that can be so helpful just to get a more expert opinion or to be able to run a case by someone and then make sure that direction that you're going is working. And I think that's a great way that we can sort of amplify the access that we do have. So thank you for, for sharing that.

What would you say has been the biggest challenge that you faced with moving to the United States and practicing there? Is there anything that sort of stands out to you, where you think wow, that was unexpected, or has it mostly been a positive experience for you so far?

Javeed: So I miss Canada, a lot. But mostly, I think that part of the opportunity has been a positive experience. And the experience has been to be part of a team that's really energized and excited to rethink and reimagine things that we can potentially do.

Katharine: Javeed, I want to thank you so much for sharing your amazing insights with us today in your experience. And it's wonderful, I think, to get that perspective of someone who's worked in both systems. And I think you've really helped us sort of unpack some of the assumptions that we have, the myths that are out there, about what care can look like in our different countries. And you've had the opportunity to see both those firsthand. So it's been a real pleasure having you on the podcast today. And I want to thank you for your time.

Javeed: Thank you so much. It's been an honor to speak to you and I hope that this was informative and useful for your audience.

Katharine: It absolutely was. So thank you again. To all our listeners stay safe and be well. To stay up to date on all our SPARK offerings, including upcoming podcast episodes, visit our website at ChildrensHealthcareCanada.ca and subscribe to our SPARK: News bi-weekly e-bulletin if you haven't already. Thanks for listening to SPARK: Conversations. And before we go show some love for your new podcast series by leaving us a review and then join us again next month. Thank you!