Dialogue Summary

Creating Resilient and Responsive Mental Health Systems for Children, Youth and Families During and Beyond the COVID-19 Pandemic in Ontario

6 & 7 December 2021

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McMaster Health Forum

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

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Dialogue

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SUMMARY OF THE DIALOGUE

The McMaster Health Forum convened a virtual stakeholder dialogue on 6 and 7 December 2021. The dialogue brought together 23 purposefully selected participants who are engaged in child and youth mental health in Ontario – three policymakers from different sectors, four managers of central-delivery agencies, four managers from healthcare organizations, four managers from community-based organizations, one representative from a professional association, three representatives from citizens' and parents' associations, one researcher, and three other stakeholders. Participants examined the problem, elements of a potentially comprehensive approach for addressing it, and key implementation considerations.

The majority of participants agreed with the way the issue was originally framed in the evidence brief, although three concerns were raised with how specific aspects of the brief were approached: 1) considering the mental health needs of children, youth and their families should be inclusive of infants and children from birth to three years of age (rather than focusing on those aged four to 25 years); 2) equity needs to be the lens through which the entire issue is considered (rather than singling out one or two specific groups); and 3) there is a need to include (and explicitly discuss) substance use as part of mental health.

In addition to the features of the problem articulated in the evidence brief, participants indicated that greater attention should be given to the following challenges: 1) there is not a cohesive 'mental health system' for children and youth in the province; 2) core components of the system are fragile and were 'stressed' prior to the pandemic (e.g., underfunding and workforce); 3) the data collection and analysis infrastructure for child and youth mental health is broken; 4) the pandemic increased demand among high-need individuals for complex, interdisciplinary health and social services; 5) social challenges have worsened as a result of the pandemic and the responses to address it (e.g., closing schools, closing non-essential workplaces, stay-at-home orders); and 6) systemic inequities within decision-making processes have been exacerbated.

There was broad agreement about the importance of the three elements of a potentially comprehensive approach to address the problems included in the evidence brief: using an equity-driven population-health management approach to address the new distribution of health and social needs as they appear after the worst of the pandemic (element 1); supporting children, youth and families to address their ongoing mental health needs as Ontarians learn to live with COVID-19 (element 2); and building on strengths identified during the COVID-19 pandemic, and addressing weaknesses exposed, to ensure that mental health systems learn and improve rapidly (element 3). Participants also emphasized the need to adopt a community-centred strengths-based approach that is focused on goals and ensuring accountability when shifting towards population-health management. This approach recognizes that 'tiers' of need are difficult to isolate and address on their own (particularly in the context of element 1). A number of participants also highlighted the need to take a balanced approach towards standardization (i.e., giving everyone access to the same package of services and supports) and culturally appropriate approaches to planning for and delivering care. Finally, they called for strong partnerships with communities and the need for a provincial and programmatic approach to child and youth mental health (not 'mental health' in general).

In discussing implementation considerations, participants identified several key barriers to moving forward, notably: 1) a dominant paradigm focused on individual outcomes that needs to shift towards collective goals; 2) colonialism, oppression and racism still underpin and permeate the system, which creates obstacles for achieving equity-focused goals; and 3) there is a lack of sustained funding for community-based child and youth mental health services.

Having discussed barriers, participants identified several features of the current landscape that could collectively create a window of opportunity to move forward, including: 1) Indigenous ways of knowing about mental health and wellness offer different perspectives from the status quo that are known to be beneficial (e.g., initiatives to support land-based programming are promising during and beyond the COVID-

19 pandemic); 2) staff working on the front line (in all relevant sectors) are untapped resources of knowledge and insights to inform the creation of resilient and responsive mental health systems; and 3) conversations are happening globally (in developed countries, as well as in low- and middle-income countries) that Ontario can learn from.

For next steps, participants underscored the need to: 1) advocate for greater centralized governance, accountability and oversight of child and youth mental health; 2) advocate for the development of robust data infrastructure; 3) promote the application of an equity lens to inform the creation of resilient and responsive mental health systems; 4) build the link between social determinants and mental health into mental health systems; and 5) adopt a problem-focused rapid-learning and improvement approach.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

The deliberation focused on the most important challenges in creating a resilient and responsive mental health system for children, youth and families during and beyond the COVID-19 pandemic in Ontario.

Most participants agreed with the way the issue was originally framed in the evidence brief (which was pre-circulated before the dialogue), although three concerns were raised with how specific aspects of the brief were approached:

1) considering the mental health needs of children, youth and their families should be inclusive of infants and children from birth to three years of age (rather than focusing on those aged four to 25 years);
2) equity needs to be the lens through which the entire issue is considered (rather than singling out one or two specific groups); and
3) there is a need to include (and explicitly discuss) substance use as part of mental health.

Participants were supportive of how the four main components of the problem were framed in the evidence brief (e.g., many long-standing issues, the pandemic and pandemic responses have affected the mental health of children, youth and families, the pandemic has highlighted new issues and exacerbated existing ones, not all assets are in place to support rapid learning and improvement).

However, most agreed that the following challenges should receive greater attention given how important they are in shaping whether the mental-health system in Ontario can meet the needs of children, youth and families during and beyond the COVID-19 pandemic:

1) there is not a cohesive 'mental-health system' for children and youth in the province;
2) core components of the system are fragile and were 'stressed' prior to the pandemic;
3) the data collection and analysis infrastructure for child and youth mental health is broken;
4) the pandemic increased demand among high-need individuals for complex, interdisciplinary health and social services;
5) social challenges have worsened as a result of the pandemic and the responses to address it; and
6) systemic inequities within decision-making processes have been exacerbated.

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

1) it addressed an issue currently being faced in Ontario;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on three elements of a potentially comprehensive approach for addressing the policy issue;
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three elements, and key implementation considerations;
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of an approach to addressing it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed;" and
10) it did not aim for consensus.

We did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior health-system leaders typically need to engage elected officials, boards of directors and others about detailed commitments.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

There is not a cohesive 'mental health system' for children and youth in the province

During the deliberation about the problem, many participants' comments indicated that the lack of a 'cohesive' system to address child and youth mental health has been put into sharp relief during the COVID-19 pandemic, with fragmentation and challenges coordinating across different levels of government (e.g., federal, provincial, municipal), different ministries (e.g., health, education, children, community and social services, justice), and different sectors (e.g., community care, primary care, acute care) becoming particularly problematic. Some participants stated that the lack of cohesion contributes to a lack of governance, accountability and oversight, in addition to making it challenging to coordinate care across a full continuum of services for children and youth (particularly those who have complex health and social needs). In discussing this aspect of the problem, one participant commented "no wonder we have navigation issues," when reflecting on how the lack of cohesion affects the ability of children, youth and their families to access the support they need.

In addition, when discussing this additional aspect of the challenge, some participants were critical of the lifespan approach promoted by many stakeholders in Ontario. In particular, some participants noted that adopting a lifespan approach could be a way to make the system appear to be seamless and cohesive, despite it not being able to fully achieve this. These participants pointed out that few providers in the system (including those who are now part of Ontario Health Teams, with the aim of integrating services across sectors) have adopted a true lifespan approach even if promoting it, with few placing focus on children and youth as prioritized populations.

Core components of the system are fragile and were 'stressed' prior to the pandemic

Participants indicated that several core components of the system were fragile and were already 'stressed' before the COVID-19 pandemic. Four core components were highlighted as particularly fragile: 1) funding; 2) workforce; 3) tailored services for children and youth with special needs; and 4) partnerships supporting children and youth mental health.

With respect to funding, participants discussed how child and youth mental health services are chronically underfunded. One participant illustrated the fragility of the funding by indicating that her organization relied on 25 funding streams. In terms of workforce, the fragility of the staff was also highlighted by several participants, with specific examples given of staff transferring to other sectors in the hope of improved remuneration and working conditions. Furthermore, some participants shared examples of organizations competing against each other to get staff, which they noted has created a culture of competition, rather than collaboration, among mental health service providers. As one participant said: "We see a movement of staff out of children's mental health to school mental health or private practice. Mental health staff [from different settings and from different sectors] have different pay, which can affect collegiality. We need a healthy staff system." This comment resonated with another participant, who indicated that it was critical to support staff in order to have a responsive and resilient system. A third participant emphasized the need for a more explicit and systematically planned workforce strategy.

When discussing tailored services for children and youth with special needs, participants noted that these types of services typically have strained capacities (e.g., those for children and youth with autism). The COVID-19 pandemic further stressed these types of services, and many participants stated that they have observed clinical regression and increased isolation among children and youth requiring these services. Additionally, some participants noted that there is a growing complexity of needs, in part due to the interruption of routine and face-to-face therapies. When discussing increasing needs, some participants with

experience planning and providing services noted that children and youth need intensive support, especially when trying to manage their condition(s) through crises, such as COVID-19.

Lastly, partnerships that kept the system together were greatly stressed during the COVID-19 pandemic. As one participant said: "Child and youth mental health services used to rely on its partners as a system, but with the pandemic, all partners are dealing with their own problems." This resonated with a second participant who pointed out: "A lot is dependent on the people making those liaisons across sectors. A lot is dependent on a web of relationships."

Data collection and analysis infrastructure for child and youth mental health is broken

The second major challenge raised by participants was related to the lack of systematic and harmonized data collection and analysis infrastructure. To illustrate the issue, one participant said that "we are working in darkness" at the local, provincial and national levels. A second participant said, "it's hard to plan and make further investments when you don't know what's happening", and a third noted that "in that fog, we get people advocating in a vacuum about scraps." Thus, most participants agreed that the current data collection and analysis infrastructure does not enable coordinated system-wide priority setting, service planning, monitoring and evaluation, and rapid learning and improvement.

The data challenge raised by participants was characterized during the deliberation as having multiple facets:
1) there is a lack of data collection and analytics capacity;
2) there is no simple, accessible, and interoperable data system;
3) a lot of data being collected is not relevant or useful;
4) important individual- and community-level data are not collected (e.g., identity data that could help address equity issues); and
5) children, youth and families are rarely at the table when designing data systems.

Regarding the first point, some participants indicated that a few organizations have been able to develop some data collection and analytics capacity about the services they provide. While many organizations work in darkness, this participant said: "We have been able to illuminate our own space. […] I have my own candle. We have small lights."

When discussing the absence of a simple, accessible, and interoperable data system, one participant mentioned the data system in cancer care as a notable example. Several participants noted that data integration across organizations and sectors is challenging (e.g., the data sit in different organizations and often looks different). One participant highlighted that cancer care appears to have a data system that was robust enough to plan during the COVID-19 pandemic: "In the cancer system, even the backlog, they could plan everything." But some participants debated whether such a data system could be feasible in the context of child and youth mental health due to the high level of fragmentation.

Regarding the second point, some participants pointed out that they are required by their funders to collect data for accountability requirements. As one participant said: "What our funders collect is not the data that can help us on the ground. We have an underground data system [for each organization], while we concurrently feed [rubbish] data to the ministries. We mush around in data." This participant went further by stating: "We have three ministries telling us what to do, and we are feeding the government with [rubbish] data. Not of any value to us on the ground. I feel worn down when people tell us about data."

Regarding the last point, a few participants indicated that we currently do not collect identity data (or data about things that frame people's identity), which could help address equity issues. In addition, the data is typically aggregated: "We all disappear when we aggregate the data."

The pandemic increased demand among high-need individuals for complex, interdisciplinary health and social services

The third additional challenge raised by participants during the deliberation about the problem was that the COVID-19 pandemic led to an increase in the demand for complex, interdisciplinary health and social services by individuals classified as having "high needs." A number of participants noted that this increase in demand has been experienced across many or most settings in which mental-health services are provided to children and youth - including in schools – which stretches existing resources thin, and doesn't allow for proactive, population-health approaches (e.g., outreach care that can be preventive) to be considered.

Some participants stated that many stakeholders in the system still approach the problem as if the problem is the child, without considering the wide range of risk and protective factors influencing their mental health. As one participant stated: "The child is the canary in the coal mine. [Many people mistakenly believe that] if we just treat the child, the rest will be OK."

Lastly, participants indicated that it was particularly challenging to match the needs of children, youth and families with the right services during the pandemic. While they were able to do so for those with acute needs, they struggled doing this for those with mild and moderate needs.

Social challenges have worsened as a result of the pandemic and the responses to address it

Participants also highlighted that many social challenges have been amplified by the COVID-19 pandemic, and by the measures taken to address the pandemic (e.g., closing schools, closing non-essential workplaces, stay-at-home orders). This includes the costs of food and housing, poverty, family stress and burnout, intimate-partner violence, social isolation, substance abuse, and a breakdown of social/support structures (to name just a few). That will create additional mental health needs in the months and years ahead. As one participant said: "The longer we spin, the collateral damages will get worse."

Systemic inequities within decision-making processes have been exacerbated

Participants also noted that the COVID-19 pandemic has put a lot of stress on mental health systems. Many system and organizational leaders turned to smaller groups for making rapid decisions in a context of uncertainty. Several participants indicated that this reaction threatens to further marginalize groups whose voices have not been heard, have been historically shut out, or have been disproportionately affected by the pandemic and the pandemic response. As one participant said: "In stress time, we shrink. But those smaller decision-making groups may not be representative and diverse people. The systems are made of the people. [If we don't have all the right people around the table, we are] not able to have the same input, which leads to impractical decisions. That will have ripple effects."

The pandemic illustrated the importance of engaging (and re-engaging) stakeholders to get the right input from all those affected by the pandemic and the pandemic responses. As one participant said, engaging the public, service users and stakeholders was not inconsistent with making rapid improvements: "Rapid improvement doesn't mean to make hurried decisions under pressure. We need good processes with the right people around the table."

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH

There was broad agreement about the importance of the three elements of a potentially comprehensive approach to address the problems included in the evidence brief: using an equity-driven population-health management approach to address the new distribution of health and social needs as they appear after the worst of the pandemic (element 1); supporting children, youth and families to address their ongoing mental health needs as Ontarians learn to live with COVID-19 (element 2); and building on strengths identified during the COVID-19 pandemic, and addressing weaknesses exposed, to ensure that mental health systems learn and improve rapidly (element 3).

During the deliberation about elements, participants identified four themes that should underpin future actions:

1) the need to adopt community-centred and strengths-based approaches that are focused on goals and ensuring accountability when shifting towards population-health management, recognizing that 'tiers' of need are difficult to isolate and address on their own (particularly in the context of element 1);
2) the need to take a balanced approach towards standardization (i.e., giving everyone access to the same package of services and supports) and culturally appropriate approaches to planning for and delivering care;
3) the need for a provincial and programmatic approach to child and youth mental health (not 'mental health' in general); and
4) the need for greater centralized governance, accountability and oversight of child and youth mental health.

We discuss in more details below the insights shared by participants in relation to the three elements in the brief.

Element 1 - Using an equity-driven population-health management approach to address the new distribution of health and social needs as they appear after the worst of the pandemic

The focus of element 1 was to support health and social systems to transition from responding reactively to children, youth and families seeking mental health care now, to being proactive in meeting the new distribution of health and social needs of the broader population.

The deliberation initially focused on segmenting the population into groups with shared health and social needs and shared barriers to accessing care (which is the first step in a population-health management approach). Some participants were reluctant about segmenting children, youth and families into 'tiers' (each tier reflecting variation in the severity, acuity, and chronicity of the mental health presentation). These participants emphasized that children, youth and families can access different tiers at different times in their journey through different mental health services. As one participant said: "Tiers are too static. Life transitions are particularly challenging periods." Another participant suggested that the THRIVE approach in the United Kingdom (an integrated, person-centred and needs-led approach to delivering mental health services for children, youth and families) could be more appropriate.

Other participants emphasized that element 1 illustrated the need for co-led and co-designed data-driven systems. Such a system should collect both individual- and community-level data.

Element 2 - Supporting children, youth and families to address their ongoing mental health needs as Ontarians learn to live with COVID-19

Participants discussed element 2 and its components to a lesser extent during the deliberation. This element focused on optimally supporting the ongoing mental health needs of children, youth and families as we learn to live with COVID-19 (and other large-scale outbreaks of infectious diseases).

This element might include:

- examining what is known about interventions to mitigate the negative impacts of the COVID-19 pandemic on the mental health of children, youth and families;
- adopting a "wrap-around" approach in systems of care for children, youth and families (wrap-around models are structured around an interdisciplinary care team and family support who create, implement, and monitor a care plan);
- developing community-based surge capacity plans for mental health;
- training the workforce in all relevant sectors in virtual, culturally adapted, trauma-informed, and strength-based strategies to support children, youth and families; and
- exploring the need for a responsive school curriculum to cope with the COVID-19 pandemic (e.g., blended learning, asynchronous and synchronous online learning, and land-based programming).

Most of the deliberation about element 2 focused on the need to adopt community-centred and strengths-based approaches. Some participants stated that mental-health systems must be built on stronger partnership with (and leadership from) communities, which is critical during a crisis like the COVID-19 pandemic. As one participant stated: "Communities need to take care of children and youth."

Several participants indicated that a lot could be learned from the experiences of First Nations, Inuit and Métis communities. On the one hand, the COVID-19 pandemic did not allow their cultural understanding of well-being (along with their knowledge systems and cultural practices) to be fully integrated in the pandemic response. On the other hand, some communities innovated with promising land-based learning and cultural programming during the COVID-19 pandemic to support children, youth and families (while at the same time engaging elders and other knowledge keepers).

Element 3 - Building on strengths identified during the COVID-19 pandemic, and addressing weaknesses exposed, to ensure that mental health systems learn and improve rapidly

During the deliberation about elements, participants reflected on the focus of element 3, which is adopting a "rapid-learning and improvement" approach to support mental health systems. Some participants noted that the COVID-19 pandemic has created a rapidly evolving context, and most acknowledged that there have been daily changes in the epidemiological situation, as well as new and emerging evidence about COVID-19 and variants of concern, the potential effectiveness of various types of interventions to respond to the pandemic, and their impacts on the population. In discussing this, participants also agreed that mental health systems may benefit from adopting an approach that allows them to learn and improve rapidly (during and between waves of COVID-19) in order to respond to the mental health needs of children, youth and families.

Five themes emerged during the deliberation about element 3, and participants framed them as a way to ensure that mental health systems can learn and improve rapidly. In particular, participants collectively identified the need for:

- a systemic approach;
- a centre of coordination and accountability (and a shared roadmap);
- harmonization of measurement and data systems;

- partnerships with community-based organizations (especially non-traditional partners); and
- a problem-focused rapid-learning and improvement approach.

Regarding the first point, several participants pointed to the need to take a system lens to child and youth mental health, and the need to better align governance, funding and delivery arrangements. As one participant said: "We need to adopt a provincial and programmatic approach. (…) We need to learn to develop care in a programmatic way." However, some participants indicated the need to unpack what we meant by a 'provincial and programmatic approach'.

With respect to the second point (related to the need for a centre of coordination and accountability, and a shared roadmap), several participants indicated that there is a need for a clear structure to support child and youth mental health. As one participant said: "It cannot be spread across ministries. There needs to be a centre of accountability and a shared plan. There is not a place to be held or hold each other accountable. [There are a lot of people] with leadership roles for different parts of the pie." This resonated with another participant: "We have wasted so much in competing against each other. Let's imagine a system and appoint those to lead the system."

The third point raised by participants (which was the subject of much discussion throughout the dialogue), was the need for the harmonization of measurement and data systems (for data at individual and community levels). This called for a robust data infrastructure (supported by information technology, data analytics, and staff), along with a core national and provincial and longitudinal data set (embedding both quantitative and qualitative data). As one participant said: "We need to focus on the data and digital system that can bring this light. [We could do] data-driven corrections. [It will] shed light where there is total darkness."

A fourth theme raised by participants related to the need for greater partnerships with community-based organizations (especially non-traditional partners). As one participant said: "We want services to be flexible and responsive. We need a shared decision-making process between communities and 'the system'." This resonated with another participant who said: "[Community-based organizations] know their communities; they have insights and knowledge. They are doorways to children and communities." A third participant emphasized the need to build on the socio-cultural, collective capabilities, knowledge and practices of communities to promote the mental health and well-being of children, youth, families and communities.

The fifth theme raised by participants referred to the magnitude of the efforts that must be put in place to bring about change, which can be daunting. One participant proposed to take a problem-focused rapid-learning and improvement approach. By tackling a common problem facing mental health systems, it could provide insights that have the potential for widespread applicability across the many problem-focused system initiatives currently unfolding. Such an approach could also be used to mobilize stakeholders around a common goal. As this participant said: "Let's focus on an area [a priority problem]. Funders [and other stakeholders] could get behind that story. Not just help us because we are drowning." A problem-focused rapid-learning and improvement approach resonated with another participant: "We need to focus on areas where there is a little bit of light to get us feedback."

Lastly, participants debated around a sixth theme, the role of standardization in children and youth mental health services. While most saw the value of standardizing data collection, others expressed concerns about efforts to standardize care (which could be seen as a "one-size-fits-all" approach). Others expressed concerns that standardization may impede innovation and downplay cultural practices that support mental health and well-being.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

In discussing implementation considerations, participants identified several key barriers to moving forward, notably:

1) a dominant paradigm focused on individual outcomes that needs to shift towards collective goals;
2) colonialism, oppression and racism still underpin and permeate the system, which creates obstacles for achieving equity-focused goals; and
3) a lack of sustained funding for community-based children and youth mental health services.

When discussing the first major barrier (dominant paradigm), participants focused on the need to shift, with one participant stating: "We cannot solve our problems with the same thinking we used when we created them." Several examples of how this might be achieved were provided by participants during the discussion, and included:

- shifting to a culture of collective thinking and collective outcomes, as opposed to focusing strictly on individual outcomes; and
- creating and supporting tolerant spaces that facilitate the sharing practices among all key stakeholders involved in providing mental health services to children and youth (both successes and failures) in order to learn and improve rapidly.

During discussions about the second major barrier (colonialism, oppression in all forms, and racism), participants all agreed that these influences still permeate all facets of mental health care for children, youth and their families. Furthermore, a few participants provided specific illustrative examples of how these create barriers for achieving equity-focused goals, with one participant stating: "Racism put us in a situation where we are underfunded, under resourced, and misunderstood."

Finally, in discussions focused on the third major barrier (lack of sustained funding for community-based children and youth mental health services), participants shared their experiences working within organizations that are constantly under time pressures to get funding from multiple funding streams, and suggested that better coordination and easier access to funds would help them focus on providing better support to children and youth when they need it most.

Having discussed barriers, participants identified three key features of the current landscape that could collectively create a window of opportunity to create resilient and responsive mental health systems for children, youth and families:

1) Indigenous ways of knowing about mental health and wellness offer different perspectives from the status quo that are known to be beneficial (e.g., initiatives to support land-based programming are promising during and beyond the COVID-19 pandemic);
2) staff working on the front line (in all relevant sectors) are untapped resources of knowledge and insights to inform the creation of resilient and responsive mental health systems; and
3) conversations are happening globally (in developed countries and in LMICs) that Ontario can learn from.

Participants also pointed to specific initiatives that could help bolster efforts framed within this context, including new legislation about child welfare for Indigenous people that could make a difference (e.g., new language legislation about promoting culture and a collective worldview, as well as initiatives by the Federal government to foster greater ownership), recent reforms in Ontario that support rapid learning and improvement (e.g., the creation of Ontario Health Teams) and a focus on mental health in other parts of government (e.g., Ministry of Education).

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

In the deliberations about next steps, participants outlined what they would bring back to their respective constituencies and how their suggestions could work to advance the proposed solutions. Together, participants prioritized some actions that could be taken to create resilient and responsive mental health systems for children, youth and families in Ontario:

1) advocating for greater centralized governance, accountability and oversight of child and youth mental health (as opposed to keeping it dispersed across different ministries);
2) advocating for the development of a robust data infrastructure;
3) promoting the application of an equity lens to inform the creation of resilient and responsive mental health systems;
4) examining the link between the social determinants of health and mental health, and embedding this in mental health systems; and
5) adopt a problem-focused rapid-learning and improvement approach

Regardless of which actions are taken, all participants agreed to two overarching principles. The first principle is that all key stakeholders should be engaged in the decision-making process, with efforts needed to amplify the voices of individuals and communities most in need, and who are often systematically omitted from these conversations. The second principle is that collective buy-in is needed to ensure cross-party (i.e., non-political) consensus and commitment for sustained action that leads to resilient and stable systems of care for children and youth with mental-health needs. One participant pointed to the United Kingdom as an example of using a 10-year multi-party agreement to achieve this, with an emphasis on not "changing course all the time" to ensure continuity in the short, medium and long term.

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