Policy Coordination to Support Manitoban Students with Mental Health and Substance Misuse

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Abstract

This dissertation examines the potential for policy coordination in supporting youth with Mental Health and Substance Use Disorders (MHSUD). In particular, it identifies existing barriers and proposes pathways to multi-level cross-sectorial policy coordination supporting youth with MHSUD in Manitoba public schools. Despite aspirations towards restorative MHSUD responses, there is ample research documenting a lack of treatment and support options for youth with MHSUDs (Scheim et al., 2013; Virgo Planning, 2018). Policy fragmentation in Canada's federalist governance model has resulted in disjointed actions in response to this important issue. Policies that work cooperatively between education, healthcare, social services agencies, Indigenous governments, federal funders and NGOs are vital in order to support Manitoban youth in schools. The purpose of this dissertation is to investigate how policy coordination might be achieved to support legislation, create policy coherence, and secure service provision to better support youth with MHSUD in schools. In particular, this dissertation responds to the research question: How can policy coordination be utilized to improve cross-sector and multi-level support for youth with MHSUDs in Manitoban schools? This dissertation draws on Multi-Level Governance as a conceptual approach, supported by insights from Advocacy Coalition Framework, and uses British Columbia as a comparator to the

Manitoban context. Methodologically, this qualitative research project engages in critical discourse analysis, examining current policy documents in Manitoba and British Columbia associated with youth MHSUD in order to map out stakeholders and illuminate both barriers and pathways to coordination, in the aim of making policy recommendations to better support Manitoban youth. Findings suggest that there is a paucity of coordination between sectored actors in Manitoba around the common issue of MHSUD and that this lack of coordination exists in a system with a scarcity of coordinating actors to spur on policy alignment and policy coalitions. Resulting out of a lack of coordination and coordinating actors, schools take on cross-sector work at the grass-roots level, which leads to inequity and barriers to care. BC offers models of higher level coordination and coordinating actors which are compared alongside the Manitoban landscape.

Territorial Land Acknowledgement

The University of Manitoba campuses are located on original lands of the Anishinaabeg, Cree, Ojibwe-Cree, Dakota, and Dene peoples, and on the homeland of the Red River Métis. We respect the Treaties that were made on these territories, we acknowledge the harms and mistakes of the past, and we dedicate ourselves to move forward in partnership with Indigenous communities in a spirit of Reconciliation and collaboration.

The work that I take up in this project considers the policy positioning of schools in the complex MHSUD multi-level policy landscape. In considering, in particular, the over-representation of Indigenous youth in Manitoba with MHSUD needs, I acknowledge the colonialist system which has spurred this inequity. As an ally, I endeavor to seek out ways to decolonize this landscape.

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List of Acronyms

ACF	Advocacy Coalition Framework
AFN	Assembly of First Nations
BC/MMHA	BC Ministry of Mental Health and Addiction
BC/MCFD	BC Ministry of Child and Family Development
BC/MH	BC Ministry of Health
BC/MEAC	BC Ministry of Education and Childcare
CBC	Canadian Broadcasting Corporation
CBO	Community Based Organizations
CBT	Cognitive Behaviour Therapy
CCSA	Canadian Center for Substance Abuse
CDA	Critical Discourse Analysis
CHRT	Canadian Human Rights Tribunal
CMHA	Canadian Mental Health Association
CPHO	Chief Public Health Officer
DBT	Dialectical Behaviour Therapy
FNHA	First Nations Health Authority
HC	Health Canada
HCMO	Healthy Child Manitoba Office
ISC	Indigenous Services Canada
JCSH	Joint Consortium for School Health
MACY	Manitoba Advocate for Children and Youth
MB/AFM	Manitoba Addiction Foundation of Manitoba
MB/CFS	Manitoba Child and Family Services
MB/MMHCW	Manitoba Ministry of Mental Health and Community Wellness
MB/ME	Manitoba Ministry of Education
MB/MMHHLS	Manitoba Ministry of Health, Healthy Living and Seniors
MB/MF	Manitoba Ministry of Families
MB/ANCR	Manitoba All Nations Coordinated Network
MB/MATC	Manitoba Adolescent Treatment Clinic
MDFT	Multi-Dimensional Family Therapy
MLG	Multilevel Governance
MHCC	Mental Health Commission of Canada
MTSS	Multi-Tiered Systems of Support
MHSUD	Mental Health Substance Use Disorders
NGO	Non-Governmental Organization
PSC	Public Safety Canada
PHAC	Public Health Agency of Canada
RTI	Response to Intervention
SCO/SECFA	Southern Chiefs Organization/ Southeast Child and Family Services Authority
TRC	Truth and Reconciliation Commission of Canada
WRHA	Winnipeg Regional Health Authority
WSD	Winnipeg School Division
VCHA	Vancouver Coastal Health Authority
VSB	Vancouver School Board

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Chapter 1: Context and Purpose of the Research

Context of the Study - Hannah's Case

The following fictionalized case sets, drawn from my own experience, the stage for this research, demonstrating how schools can become sites where limited policy coordination has direct implications for students and school administrators. I take, as a means to demonstrate competing policy sectors responding to youth MHSUD, an exemplar of an interaction with a student in my role as a public-school administrator. The student, whom I will refer to as "Hannah," presented at school as dysregulated, agitated, and worried. Hannah identified as an Indigenous female student who shared that she was daily consuming drugs and alcohol, often in excess and often alone. She indicated that she was presently under the influence of drugs. Hannah went on to disclose a recent assault, long-standing abuse, and ongoing mental health concerns, including dissociative episodes and a suicide attempt in the last year. Given the gravity of the concerns, it was clear that Hannah required immediate support from a multitude of sectors, who were each driven by their own policies and procedures. Education policy dictated that Hannah received: (a) a disciplinary response (in this case, a suspension) for being under the influence of drugs at school; (b) a referral to an Addictions Foundation of Manitoba (MB/AFM) counsellor; and (c) an immediate report to All Nations Coordinated Response (MB/ANCR) regarding the assault. Child and Family Services (MB/CFS) policy dictated that following her disclosure, Hannah should meet with an abuse and assault investigator. Concerns raised by the school—namely that Hannah was having difficulty accessing basic health supports (including a necessary physical exam following her assault), that she did not have access to cultural or spiritual supports, and that there had been no regular medical follow-up since her suicide attempt last year—were deemed beyond MB/ANCR's jurisdiction. In addition, Hannah was referred to

the justice system (via the Winnipeg Police Service) to re-report her assault claims. Hannah did not have a family doctor and in the days following, when significant psychiatric symptoms were seen in the school environment, school staff pursued options to get Hannah the medical support she needed. The school principal called home and requested that family take her to Children's Hospital (which they declined), and the school social worker accompanied Hannah to the emergency room where she was seen and released with the promise to put her on a waitlist to access psychiatric supports. The hospital refused to share information with the school social worker who was case managing since she was not her legal guardian. A call to her regional health authority to look at supports close to home indicated that Hannah was also on a waitlist for an outpatient program for psychological symptoms.

In subsequent weeks, Hannah's school-based therapist[1] worked with the school-based social worker to identify whether the psychiatric referrals at the hospital or the regional health authority were met with follow-up appointments or whether MB/CFS could support with accessing mental health supports, trying to facilitate a basic medical appointment for Hannah and her family. When no further action by the medical system or MB/CFS regarding the ongoing substance use and psychological distress had been identified weeks later, the school-based team assisted Hannah in making another referral for psychiatric supports, this time at Manitoba Adolescent Treatment Center[2] (MB/MATC). Due to a missing signature on a form by the caregiver – who assumed that the paperwork already submitted to a clinic doctor, children's hospital, and regional health authority for outpatient programming were sufficient—Hannah's spot was given away. A short time later, substance use and suicidality concerns at school resulted

[1] Not all schools have on-site therapy supports, but some schools—in absence of provincial supports and directives — have implemented a pilot projects including staffing trauma counsellors on site in schools.
[2] MATC, like the emergency room Hannah visited, is run by the Winnipeg Regional Health Authority. However, referrals to this treatment center are run separately.

in a 911 call and another visit to the emergency room, again with a quick discharge and placement on a waitlist to see a psychiatrist. Six weeks after the initial incident, Hannah had not heard back regarding the MB/CFS investigation, she had not been able to see a family doctor, had not been prescribed any medications, and did not have a referral to psychiatrist, despite worsening symptoms. The school continued to be the sole site for ongoing triage, support, and referral, but neither Hannah's health authority, MB/MATC, the emergency room physician, nor the MB/CFS investigator were able to work together or share information to support Hannah with accessing additional services.

This example highlights the sheer number of policy sectors and independent actors that had been involved to support Hannah—*at the school's request*. The result was that sector actors were following their own internal mandates, wait times, and triage mechanisms rather than focussing on Hannah's own care needs. After weeks of time and professional support, the decision was made to involve the Manitoba Advocate for Children and Youth (MACY)—an independent body of the Manitoba legislature tasked with working with stakeholders to support children and youth in Manitoba—to force some coordination between sectors.

Certainly, this is a dire representation of how policy sectors responded to a concern with disjointed responses that were neither fiscally responsible, nor ethically responsible to the youth they are intended to serve. What Hannah required was wraparound, culturally responsive approach to substance use, mental health, medical, and social supports. Instead, what she received was a lack of support from MB/CFS to facilitate medical care and disjointed referrals to multiple access points for substance use and mental health care. Ongoing school-based safety issues, in which school clinical supports made referrals to intensive medical interventions, continued while Hannah continued to attend school, albeit with minimal engagement, and

ongoing academic, social, and behavioural concerns. Hannah's case exemplifies the ways that existing provincial policies lack the means to work symbiotically with other policy sectors putting students at direct risk.

Research Problem

This dissertation examines the potential for policy coordination in supporting youth with Mental Health and Substance Use Disorders (MHSUD) in Manitoba public schools. The research problem addressed by this dissertation is the absence of effective cross-sectorial policy coordination that could support youth mental health and substance use needs in Manitoba, using the British Columbia policy context as a comparator. Specifically, this research focuses on the ways in which policy coordination—or a lack of policy coordination—impacts students, school administrators/staff and school-based supports available to students. In our Canadian public-school context, all youth have equal right to education (Public Schools Act, 1988). Consequently, schools do not implement waitlists, complete criteria checks, screen or deny access to students' path to education. Yet, many students need supports beyond academic ones (for example, social, emotional, and health supports). In such contexts, school staff become de-facto service providers for students and families with a multitude of health and social issues, including MHSUD (Connors et al., 2021). Given this backdrop, some have argued that "school settings have become the most common provider of mental health interventions and services for youth" (Ziomek et al., 2019, p. 28).

In Canada's federalist governance context, the federal government controls governance of some sectors while deputizing provinces generate policy in other policy sectors overseen by individual ministerial units. These provincial units work to provide guidance for a multiplicity of

issues, including legislation and policy to be implemented with youth, based on ministerial mandates, interests and beliefs. As part of Canada's federalist structure, regional providers work within provincial structures with their own service delivery frameworks that may not always be aligned (Wietkoricz, 2019). In the case of sectors responding to youth MHSUD—education, social services, justice and health—these sectors all have separate provincial ministries determining their own directives to respond to youth MHSUD provincially. Furthermore, Health Canada (HC) and Justice Canada (JC) provide federal oversight over provincial ministerial directives. The Canadian federal government maintains control of First Nations schools and Indigenous Services Canada (ISC) orchestrates services provincially. Thus, in the Manitoban context where 29% of youth are Indigenous, and where school staff liaise with social and health supports for youth, there is a complex and messy layer of governance mechanisms present, mixing federal governance within the provincial legislative landscape (Verdun & Wood, 2013).

This multi-level context of policymaking within federalism's landscape of siloed ministries often results in incongruencies on common issues (Conteh, 2013). Within this context, and in responding to youth with MHSUD, school staff are required to navigate, alongside youth and their families, complex policies and guidelines from multiple levels of governance and numerous policy sectors, including education, health, social services and justice (Reinberg & Fefer, 2017). The issue of student MHSUD is often conceptualized differently in provincial education policy compared to other policy sectors such as health policy or social services policy. For example, in health care fields it may be centered in conversations of service provision, while in education it may be centered as a disciplinary issue. As a result, there are fractured responses to common policy issues, creating confusion and further limiting access to necessary supports for students (Chafouleas et al., 2020).

In recent years policy in general, and education policy in particular, has become increasingly complex and multilayered, with relevant stakeholders positioned across international, transnational, national, provincial and local/school levels (Peters, 2015). This complexity requires coordination between levels of government, between ministerial units and with non-governmental actors. Policy coordination can be understood as the capacity to coherently organize the machine of government that in a federalist context is made up of "inherent tendencies of fragmentation and autonomation" (Braun, 2008, p. 291). Yet, organizing or coordinating policy goals and outcomes is difficult within contemporary modes of governance, where policy tends to be multi-sector and multi-actor with increasing iterations of competing, duplicating, or misaligning policies and sectorial goals (Peters, 2015). In education contexts, policy coordination efforts have become a means to overcoming dissonance and inefficiency across policy sectors to ensure that school staff are able to support all aspects of youth development in schools in a coherent and holistic way. This dissertation aims to identify and examine both shortcomings of, and opportunities for, coordination of policies directing responses to youth MHSUD in Manitoba to support effective school-based responses and coordinated multi-sector approaches to youth with MHSUD.

Rationale and Purpose

Mental Health and Substance Use Disorders (MHSUD)[3] in Manitoban youth are measured to be almost double the national average with one in seven youth receiving a mental illness diagnosis (Virgo Planning, 2018). Additionally, following COVID-19, there has been

[3] I use the term MHSUD because of the significant amount of research linking mental health and substance use disorders (Kirsche et al., 2020; Quinn et al., 2019). Increasingly, mental health and substance use are discussed in concert, de-stigmatizing responses to substance use, and supporting current research on effective treatment and supports (Center for Addiction & Mental Health, 2021; Wellness Together Canada, 2021).

mounting public concern regarding worsening mental wellness and increased drug use in Manitoban youth, particularly among Indigenous youth (Lefebyre, 2020). Furthermore, questions about impacts of the Canadian legalization of marijuana on youth, and continued declarations of a Canadian "opioid epidemic" are prevalent (Zafar, 2020). Finally, with federal and provincial commitments to the Truth and Reconciliation Commission's Calls to Action, it is becoming increasingly clear that MHSUD supports and trauma-informed care are paramount to the work of reconciliation (Yeung, 2021), especially given the over-representation of Indigenous youth with MHSUD diagnoses (Government of Canada, 2021). The documented concerns regarding youth MHSUD are contextualized within emerging changes to social norms whereby substance use, abuse, and dependency are understood as indicators of languishing mental health rather than indicators of an individual's (failing) character (National Institute on Drug Abuse, 2020; Wisdom et al., 2020). This has prompted calls for restorative rather than punitive responses to MHSUD (Howell, 2019; Payne & Welch, 2018). Despite moves towards restorative MHSUD responses, and despite the knowledge that negative outcomes associated with drug use and dependence disproportionately affect youth (Young et al., 2011), there is ample research documenting a lack of treatment and support options for youth with MHSUDs (Scheim et al., 2013; Virgo Planning, 2018). This policy fragmentation provides a direct rationale for this dissertation, as school personnel aiming to support youth in schools become stuck in this quagmire of fragmentation, ultimately negatively effecting schools' responses to youth with MHSUD.

Though there is a plethora of research calling for treatment of co-occurring MHSUD, data also indicates that youth are often not able to access services in a timely manner (Costello et al, 2014; Settipani et al, 2019; Wang et al, 2007). Untreated MHSUDs in adolescents result in

short term concerns such as academic struggles and increases in delinquent behaviours, and interactions with the criminal justice system (Wisdom et al., 2020). Long-term neurological changes resulting in ongoing dependency, psychiatric disorders, reduced education and life outcomes, and premature death are also correlated with youth MHSUD (Wisdom et al., 2010). Given this context, the ability for schools—who are working with youth daily—to be sites of meaningful support for youth with MHSUD is paramount. Foley (2019) argued that the crisis in youth mental health has resulted in federal and regional initiatives that have made addressing these concerns a school priority. Blewitt et al. (2021) argued that mental health supports in schools are foundational to a public health response to MHSUD with an attempt to "[promote] health through the organized efforts of society" (p. 17). However, Ziomek and Heckman (2019) argued that despite pushes to have schools take on this work, in the absence of multi-tiered, multi-faceted and multi-sector systems to support MHSUD, teachers and counsellors are forced to take on roles in schools providing mental health supports in absence of proper supports from trained multi-sectoral actors.

I argue that policies that work cooperatively between levels of governance and between education, healthcare, social services agencies, Indigenous governments, federal funders (such as Jordan's Principle), and Non-Governmental Organizations are vital in supporting Manitoban youth. **The primary purpose of this dissertation is to investigate how policy coordination might be able to support policy and legislation coherence, and thus to secure service provision that better supports school-based responses to youth with MHSUD.** In support of this primary purpose, four supporting purposes for this work include:

(1) This dissertation analyzes the current Manitoban policy context alongside a comparator. While Ontario has made some strong policy shifts in the last five years towards

decriminalization of narcotics (Pagliaro, 2021), British Columbia has been the most progressive jurisdiction in terms of efforts to decriminalize narcotics and invest in harm-reduction programs (Smith, 2021). In terms of policy-based responses to youth with MHSUD, British Columbia was the first province to establish a Ministry of Mental Health and Addictions (BC/MMHA) (Province of British Columbia, 2017). This in itself is a move towards policy coordination as this ministry works by straddling the actions of the ministries of health, social services and education. Examining and comparing the policy context of Manitoba to that of British Columbia is intended to provoke comparisons and questions about provincial policy landscapes to trigger learning.

(2) This study aims to explicate the array of policies directing responses to youth with MHSUDs, and to unpack the types of policy paradigms that exist for youth with MHSUDs. Increasingly, mental health and substance use are discussed in concert as a singular policy sector, de-stigmatizing past punitive responses to substance use, and in keeping with current research on effective treatment and supports (Center for Addiction and Mental Health, 2021; Wellness Together Canada, 2021). Youth with mental illness are twice as likely to have a substance use disorder compared to the general population and MHSUDs are the leading cause of disability in Canada (Canadian Association of Mental Health, 2022). Therefore, it is important that schools, tasked with supporting children and youth day in and day out, are able to navigate multi-sector policy landscape in order to support healthy youth development.

(3) This research project is interested in unpacking and analyzing the discourses present in relevant policy sectors (primarily health, education, and social services) to determine if current policies and legislation—which formally direct actions for and with youth within the context of Canada's federalism: (a) are reflective of the needs of youth; (b) are aligned with each other; and (c) could better employ policy coordination strategies to support youth. From a legislation

perspective, the policy sectors of health, social services, and education are predominantly tasked with legislating responses for youth with MHSUD, and in complex systems such as this, policy often becomes reflective of bureaucratic needs rather than of youth needs (Braun, 2008). Given that policy and service provision models, developed in isolation of other policy sectors, may limit access due to bureaucracy (Cairney, 2012), understanding the limitations of the current policy landscape is vital in order to inform revision to better support youth.

(4) This project seeks to uncover the values and beliefs that underscore the policy actions in response to youth MHSUD. Despite research demonstrating links between mental health and substance use, social responses to MHSUD continue to be weighted with stigma and judgement (Wisdom et al., 2011). Furthermore, given that policy reflects beliefs and social norms of a particular society (Rizvi & Lingard, 2009), and in such value-laden policy areas as MHSUD (Stimson & Fitch, 1999), it is important to uncover the norms that are being supported in the Manitoban policy context, and also to look to other jurisdictions for alternative pathways to support youth.

Research Questions

Coordination between sectors can occur at varying degrees of implementation—at a very basic level, there may be information sharing or service coordination between sectors or within sectors, without overt changes in policy mandating coordination (Hogl & Nordbeck, 2012). At a higher level, policy coordination and policy integration represent opportunities for supporting cross-sector-informed policy implementation based on shared goals (Braun, 2008). This thesis will explore the types of coordination mechanisms currently employed in Manitoba and British Columbia for youth with MHSUD, and the types of coordination models which might better

support students and the school personnel who work with them each day. The main research question that guides this research is: ***How can policy coordination be utilized to improve multi-sector and multilevel support for youth with MHSUDs in Manitoba public schools?***

Using British Columbia as a comparator, additional research questions are:

1) What policy stakeholders and corresponding documents currently guide responses to youth MHSUD in general, and school-based responses in particular in both MB and BC contexts?
2) What are the interests, beliefs, policy actions, and coordination mechanisms that are implicit and explicit in these documents?
3) What are the documented impacts of the current policy landscape for youth in both jurisdictions?
4) How do the documented interests, beliefs, policy actions, and coordination mechanisms compare between sectors, jurisdictions, and levels of government?
5) What can we learn from provincial comparisons? What recommendations for policy coordination can be made to support MHSUD supports in Manitoba schools?

Significance of the Study

This research is both timely and significant to the current research literature and practice in a number of ways. First, this dissertation makes an important empirical contribution. Despite the documented needs for MHSUD youth care and identified barriers to care, there has not been a full scoping analysis of the policies in Manitoba (or to the knowledge of the researcher, in any other provinces of Canada) that direct responses to MHSUD youth in general, and school-based responses to MHSUD in particular. This thesis will provide a unique empirical data set of the existing policy documents from all stakeholders regarding youth MHSUD responses

provincially. Without understanding the full policy landscape in a multi-layered governance system, it is not possible to direct full attention to reforming or improving policy guidelines.

Second, this dissertation makes an important theoretical contribution by adding to policy coordination literature. While Multi-level Governance and the Advocacy Coalition Framework have both been used independently as conceptual frameworks to examine policy contexts in Canada, to date there has been no research that combines these frameworks to investigate opportunities for shared values and policy coordination at different levels of governance. The theoretical grounding used in the thesis is a useful approach to explicate dualling purposes, redundancies, and gaps between governance levels and policy actors.

Third, the thesis makes an important contribution to policy work by adopting a cross-sectorial lens to policy analysis that is currently lacking. A recent report commissioned by the Manitoban government called for significant overhauls of MHSUD supports in Manitoba, including facilitating more straightforward access to service provision (Virgo Planning, 2018). Following this report, the provincial government developed a document, *Pathway to Mental Health and Community Wellness* (Government of Manitoba, 2021), which makes a series of declarations related to next steps for MHSUD collaborative care in Manitoba. However, while the Virgo Report (2018) and the subsequent policy pathway document reference the need for coordination with other policy sectors, their investigation has not served to explore, identify, or consider the full scope of policies outside of the health sector legislating responses to MHSUD in general or youth MHSUD in particular. Dasgupta et al. (2018) argued that socio-economic determinants are not typically considered when we frame MHSUD as solely a health policy issue, and therefore, we ought to "compel reformation of laws rooted in racism and subjugation as a matter of correcting injustice and equity, not only promoting better health" (Virani &

Haines-Saah, 2020, p. 162). That is, by framing MHSUD only as a health issue, not a social issue, educational issue, or an issue of justice, we limit our policy responses and the ability to actually support individuals who need care. Thus, the dissertation makes an important contribution by demonstrating the need to apply the full scoping approach to understand the current weaknesses of existing policy landscape and provide theoretical guidance on future attempts at coordination, particularly when education is concerned.

Fourth, the thesis makes a significant methodological contribution. From a data set perspective, this dissertation examines the data sets that have not yet been tapped into, providing a unique analytical lens for researchers and policymakers. Despite a wealth of data in the form of Provincial Children's Advocates' reports nationally, there has been no critical discourse analysis of these documents to inform current research on the experiences of Canadian youth in accessing MHSUD supports. Provincial Advocates' offices are in place in most provinces and territories in Canada, and their work includes gathering first-hand stories from youth, families and communities in order to act as a checking mechanism to monitor public-sector policy impacts on Canadian youth (Canadian Council of Child and Youth Advocates, 2021). The mandate of the Advocates' offices is to call to order all public sectors (including health, social services, and education) in their response to youth in general and marginalized youth in particular. Thus, Advocates' reports are a vital data set that would benefit from national and jurisdictional thematic and critical discourse analysis (CDA). This analysis can be used to identify the impacts of existing MHSUD policies, bureaucratic structures, and service provision frameworks for youth. Furthermore, CDA can be employed as a means to identify the actuality of youth and family experiences alongside the discourses inherent in policy documents. A critical discourse analysis of this literature serves as an illuminating lens into the lived experiences of youth to

identify both barriers and opportunities for youth in the current policy landscape. Furthermore, it is important to identify who has voice in this move towards coordination and the beliefs and interests that are being supported in this coordination model. Consideration of whether those belifes and interests are shared in other jurisdictions are noteworthy in examining Manitoba's policy subsystem.

Fifth, this dissertation has direct practical value given the recommendations it makes regarding cross-sectorial responses to the policy issue of MHSUD. There have been changes to the larger policy context of substance use in Canada—including the legalization of marijuana, the treatment of MHSUD as a health issue, increasing harm reduction efforts, and pushes for decriminalization. However, there has not been research linking more progressive approaches to substance use policies with the impacts that those progressive approaches have on school-based responses to youth MHSUD. A comparison of Manitoba's policy context in contradistinction to a policy jurisdiction with more progressive substance-use responses may provide insights into how non-disciplinary responses to MHSUD have been supported by policy coordination and integration in other jurisdictions. This research identifies opportunities for improvement in the Manitoban policy landscape for the support of youth with MHSUD.

Overview of the Dissertation

This dissertation conducts a multi-sector, multi-level policy analysis to inform opportunities for improved policy coordination to support school-based responses to youth MHSUD. To that end, I first undertake a literature review outlining: (a) basic tenets and applications of policy coordination; (b) the Canadian federalist context for policy coordination; (c) historical responses to MHSUD and the shifting ethical positionings of MHSUD policy in

Canada; and (d) the context for policy coordination situated in the unique MHSUD policy contexts of Manitoba and British Columbia. From there, I outline the theoretical and conceptual framework for this project by introducing Multi-Level Governance (MLG) and the Advocacy Coalition Framework (ACF) and their applicability to this project. I then present a methodology of ACF Stakeholder Analysis to be used in the project and outline the specific methods that were utilized to map out stakeholders, documents, and conduct an analysis to uncover opportunities for policy coordination. Findings are then shared, followed by a discussion of as related to the research questions.

Chapter 2: Literature Review

In this chapter, I divide my literature review into four sections: (1) a review of policy coordination research, including levels of coordination, barriers to coordination and opportunities for implementation of coordination models; (2) a review of the political context for policy coordination, including an overview of Canada's decentralized federalist model, demonstrating how it impacts the policy coordination and implementation in Canadian jurisdictions; (3) a review of the social context for policy coordination, including a background of historical school-based Mental Health Substance Use Disorders (MHSUD) policies and emerging research that plots a new path rooted in cross-sector cooperation and restorative approaches; and (4) a review of the policy context for policy coordination, including a review of both Manitoba's and British Columbia's specific policy landscapes and implications for policy coordination relevant to MHSUD in schools. Given that Canadian education operates within a political context of federalism, examining the legislative context of MHSUD is vital to understand the bottlenecks in service implementation.

Policy Coordination as a Mechanism to Support Cross-Sector Work

Policy coordination refers to actions and protocols that are undertaken in order to align policies and policy actions between sectors for improved outcomes (Braun, 2008; Peters, 2015). During the past few decades, there has emerged a plethora of policy coordination research, prompted by increased complexity involved in webs of policymaking. Policy coordination has been applied to energy policy (Bistline et al., 2020), fiscal policies in the European Union (Haas et al., 2020), and multi-sector climate change policies (Russel et al., 2020), in addition to federalist policy contexts such as Canada's (Banting & McEwen, 2018).

Peters (2018) referred to policy coordination as a design task, where work is undertaken to ensure policies work together. In the case of the education sector, policy coordination is a necessary part of working with youth, as social, health, and justice needs (among others) of students are often addressed in the school environment. Hogl and Nordbeck (2012) suggested policymaking in the contemporary sphere can best be understood as navigating "fragmented landscapes of interdependent arenas" (p. 112), and thus policy coordination efforts are a means to examine cross-policy contexts involving multiple organizations or branches/levels of government in an attempt to overcome dissonance and inefficiency. The idea of fragmented landscapes is particularly true in Canada's decentralized governance system, in which most public services are not run by the federal government but rather delegated to provinces. In more centralized governments, public services tend to be more uniform, insensitive to the needs of different geographical regions and difficult to reform (Banting & McEwen, 2018). By contrast, decentralized models rely on sub-state governments which, in theory, "are freer to innovate and tailor programmes to the preferences of local residents; and, in the view of many, such governments can be held to account more effectively by voters" (Banting & McEwen, 2018, p. 107). Policy coordination—both between policy sectors (horizontally) and between levels of governance (vertically)—becomes more complicated in a decentralized model as the number of mandates, stakeholders, and bureaucratic systems grow. In this section, I identify facets of policy coordination in Canada's decentralized system, including horizontal and vertical coordination, degrees of coordination, structures that facilitate coordination, and barriers to coordination.

Facets of Policy Coordination

The lens of policy coordination helps to reveal and examine conditions that may be conducive to implementing: (a) either horizontal or vertical coordination, in order to reduce

fragmentation between sectors (Wallner, 2017); and (b) either low-level service-based coordination or higher-level policy integration (West et al., 2021). Policy coordination takes the form of "mutual adjustments that [cause] governments to pursue different policies than they would have chosen, had policymaking been unilateral" (Webb, 1995, p. 11). Policy coordination, "the extent to which organizations attempt to ensure that their activities take into account those of other organizations" (Jungblut & Rexe, 2017, p. 53), can be prompted in a number of ways. Wallner (2017), Benz (2009), and Jungblut and Rexe (2017) agreed that coordination can take the form of: (a) coercion—whereby hierarchies with formal rules force adaptation towards coordination. For example, Healthy Child Manitoba's (2013) *Education and Child and Family Services Protocol for Children and Youth in Care* document outlines mandated standards of care for social workers and educators when it comes to programming for youth in care; (b) competition— in which networks build coordination based on trust and shared resource dependency. For example, singular triage mechanisms that support and refer individuals to competing service providers; or (c) cooperation—through negotiations or compromise through bargaining or competition leading to subsequent mutual adaptation. For example, Addictions Foundation of Manitoba (MB/AFM) has co-developed substance use counselling models within Manitoban school divisions so that existing substance use counselling structures can be implemented in school-based contexts (River East Transcona School Division, 2022). That is, coordination may be vertical or horizontal, forced or voluntary, intended to create coherence or to reduce competition, or a means to meet short-term or long-term goals (Jungblut & Rexe, 2017). Horizontal coordination, vertical coordination, and integrated policy coordination are discussed in the following sections.

Horizontal coordination. Horizontal coordination refers to coordination between policy sectors at shared levels of governance that can occur for example, between provincial ministries, or between regional/local service providers. In line with Wallner (2017), Benz (2009), and Jungblut and Rexe (2017)'s research on policy coordination in general cited above, Wiekorowicz et al. (2011) have presented similar findings regarding governance models that support specifically horizontal relationships. Wiekorowicz et al. (2011) argued that there are three types of governance models or actions to support horizontal coordination: (1) mutual adjustments, in which two or more organizations choose to make voluntary changes towards coordination without formal mechanisms; (2) imposed corporate structures, in which regional or provincial authorities initiate changes towards coordination; and (3) purposeful alliance structures, in which autonomous organizations form a coalition to change large scale practices towards desired coordination goal. Mutual adjustments can be made to support horizontal coordination when regional service models have a good deal of autonomy and where complexity of service offerings are complicating service delivery (Wiekorowicz, 2010). In horizontal relationships, coordination may be implemented at a grass-roots level between ministries or service providers at the same level of governance. However, often there is pressure—top-down or bottom-up—to align structures to "facilitate the likelihood of achieving horizontal objectives to reduce overlap and duplication" (Bakvis & Juillet, 2004, p. 8). Thus, it may be that in some cases vertical governance structures are required to prompt horizontal coordination efforts since shared beliefs at the "top of decision making at the ministerial level…[results in] stronger integration on the operational level" (Braun, 2008, p. 289). Simply put, optimal horizontal coordination begins with a shared value set among stakeholders at the same level of governance, which is most often implemented via a top-down directive via coercive or imposed corporate structures.

Vertical coordination. In Canada's federalist context, provincial ministries like health, which have a corresponding federal ministry must typically respond to federal directives, as opposed to social services and education sectors, which do not have federal ministries and are run by provinces. Correspondingly, regional actors must respond to provincial ministries orchestrating legislation in discrete ministerial sectors. In the case of regional actors implementing or working within a top-down hierarchical system, the uptake of formal policies at lower levels of governance is often context dependent (Stevens & Hanschuka, 2014). In vertical systems, one of the most significant contextual factors at play is the ability of local-level actors to implement directives from higher level governments with fidelity. If higher level decision makers are not attuned to the ability of local level actors to implement policy directives—due to lack of resources, training, or political will—policy implementation will be affected. Furthermore, institutional environments—the constellation of policymakers, stakeholders, advocacy groups, provincial legislation, and professional associations—are unique to individual regions and have a significant impact on how effectively policy is implemented (or if it is implemented at all) (Stevens & Hanschuka, 2014). Thus, jurisdiction-specific examinations of opportunities for policy coordination are necessary to inform implementation models (Leo & Enns, 2009).

A spectrum of coordination: Service coordination to policy integration. Policy coordination can be applied at any part of the spectrum of policymaking, from a partnership between two independent service providers, to a ministerial directive enacted between provincial ministries, or even a federal directive. However, in a very simplistic or binaried sense, coordination may be seen guiding policy implementation either: (a) at the service provision level—for example, through sharing of information between service providers, shared triage

mechanisms to reduce redundancies, or the ability to work with one access point for multiple service providers; or (b) at the policy integration level, which takes advantage of higher level ministerial policy coordination opportunities, such as, shared funding models, specific unit/advisory bodies to oversee coordination, and co-implemented policy and models, which utilize re-designs of ministerial policies to potentially break free of historical jurisdictional borders.

Service coordination. Service coordination became a popular concept in the 1970s and 1980s with the rise of case management in social work (Dunst & Bruder, 2006). From a systems management perspective in the context of MHSUD, the concept of service coordination is intended to provide youth and families with synchronized supports. Service coordination is employed in complex organizational systems, where a lack of organizational knowledge is a barrier to service provision, and where higher-level policy coordination has not been employed, which is often the case in Canada's federalist system. Service coordination has been applied to early intervention and disability services (Dunst & Bruder, 2006); maternal mental health, partner violence and substance use (West et al., 2021); HIV treatments and supports (Towe et al., 2020); and Jordan's Principle (Gerlach, 2020). Essentially, service coordination involves "identifying point persons to facilitate service access and coordinate care across specialists" (Settipani et al., 2019, p. 12). Service coordination "requires the implementation of more formalized integration strategies to better incorporate [a] continuum of care" (Wictorowicz et al., 2011, p. 15), including to support sustainable coordination efforts, rather than "one-off" episodes of coordination.

Dunst and Bruder (2006) argued there are three types of service-coordinator models: (1) dedicated and independent—in which there is a designated role of an identified service

coordinator; (2) dedicated but not independent—in which intra-agency models place existing staff in coordinator roles; and (3) blended—in which staff offer both coordinator and intervention services. In very complex systems (such as systems responding to youth MHSUD) with overlapping mandates, waitlists, and varying service provision models, independent staffing may be necessary to facilitate coordination for individuals. This is particularly true when existing service sectors have independent rather than co-developed service delivery frameworks (Dunst & Bruder, 2006), often as a result of a lack of policy integration. In this context, the differentiation between service *coordination*— "actively managing all elements of the continuum of… services" (Witkorowicz, 2019, p. 16)—and *integration* of policy to coordinate services—"collaboration between diverse providers through organizational, administrative, service delivery [and] clinical approaches by linking patient care" (Witkorowicz, 2019, p. 17)—is an important distinction.

West et al. (2021) argued that in the absence of meaningful policy integration, service coordination takes the form of "a purposeful organization of activities between two or more organizations to facilitate, in partnership with the family, the delivery of the right services" (p. 634). Without coordination of directing policies, service coordination takes on programming to support triage, referral processes, linkage between service providers, and follow-up. Service coordination allows multiple actors to co-implement the pre-established policies within their respective sectors, rather than working to align policies between sectors. Thus, service coordination is best supported within a broader context of higher-level policy coordination (Dunst & Bruder, 2006). While service coordination is enacted by local actors, policy coordination to support such endeavours requires coordination at the top of the legislative chain.

Policy integration. Candel and Biesbroek (2016) argued that in an ideal world, policy integration efforts would ensure that all policies that influence one another would be designed in ways that produce synergy, or the very least, reduce conflicts. Similarly, Hogl and Nordbeck (2012) argued that whereas policy coordination may involve very small-scale changes at a service provision level, at its core its goal is to minimize contradictions between policy sectors (Jungblut & Rexe, 2017). Thus, in an attempt to minimize policy contradictions, at the more complicated end of the policy coordination spectrum, policy integration seeks policy to support common, trans-domain goals (Jungblut & Rexe, 2017). Implementation of common, trans-domain goals within policy integration allows "overcoming institutional misfit by structurally and procedurally reflecting the substantial interdependencies in the problem domains" (Hogl & Nordbeck, 2012, p. 113). In this sense, integration can take two forms: blending (existing) policies into a unified whole, or incorporating the concerns of one policy area into another to create a new policy framework (Jungblut & Rexe, 2017). Hogl and Nordbeck (2012) argued that policy integration—rather than small scale coordination efforts—requires: (1) comprehensiveness—inclusivity of all policy actors at the input stage; (2) aggregation—thorough evaluation of alternatives at the processing stage; and (3) consistency—ensuring that policy actions in different sectors are in accord with one another. Furthermore, one policy sector can sometimes push other sectors to develop coordination, but if policy coordination is seen solely from the perspective of one sector, then there is not opportunity for true policy integration (Bakvis & Julliet, 2004). That is, policy integration requires a shared value positioning or shared beliefs regarding a common goal and political will at higher levels of governance to enact change with all policy sectors at the table. In comparison with lower-level service provision within an existing policy framework, policy integration is a much taller order.

Factors that Enhance Policy Coordination

Policy coordination researchers lay out a number of frameworks for understanding how coordination can be implemented at different levels of the policymaking process. Investigating factors that enhance coordination is key for policymakers as it allows systems both to predict opportune times for policy change, and to build systems, which might produce optimal cohesion. In this section, I explore shared beliefs, trans-domain interests, and contextual factors as enhancers of policy coordination.

Shared beliefs and policy interests. Shared beliefs about a common policy issue and shared interests or goals regarding policy intents among stakeholders are integral to policy coordination. Shared beliefs and values, which act as ethical standards that are commonly accepted, serve as a unifying force which can guide the behaviour, decisions, and interactions of individuals within a policy subsystem (Jessop, 2004). Braun (2008) suggested that rather than forced internal cooperation based on systems of control, "external coordination under the influence of moral contracts at the top of decision making at the ministerial level…[results in] stronger integration on the operational level" (p. 289). Jessop (2004) reiterated that at a basic level, cooperation (for example, a pooling of resources or a ceding of policy autonomy) requires common interests and shared beliefs about a common issue, facilitated through communication, which can essentially be implemented as inter-organizational politics. In that vein, Hogl and Nordbeck (2012) argued for the inclusion of a "first-order operational principle" (p. 113). That is, a guiding set of beliefs about a policy problem with identification of shared interests towards an overarching goal that all policy domains agree to work towards. In their context of

environmentalism, for example, Hogl and Nordbeck (2012) identified a first-order principle of environmental sustainability as a primary and common goal. In the area of youth education, mental health and drug use, a first-order principle may be agreeing that policy actions need to first and foremost take into account the wellness of the whole child/whole family. Peters (2015) reiterated the importance of first-order principles when he argued, "if health policies are to be effective, they should be coordinated with social, environmental and education programs; with these efforts to coordinate, there is a better opportunity to serve the whole client" (p. 222). Peters (2015) suggested that many of the instruments necessary for policy coordination change already exist within bureaucratic systems, including technical knowledge of policy areas, processes and pathways for decision making, and political resources/systemic knowledge. However, the autonomy of public sectors, their general stability over time, and entrenched processes can also impede coordination and change.

Policy learning. Related to shared beliefs and policy interests is the understanding of policy learning. Understandings of policy learning hold that, "all politics and policy issues involved the accumulation of data about problems and solutions in context of social interactions (Mayson, Scholten & Weible, 2017, p. 161). In this sense, policy learning over time has the potential to contribute to adjusting understandings and beliefs related to public policy so that beliefs and interests in similar areas may become more aligned (Dunlop & Radaella, 2013).

Jann and Wegrich (2007), in their work on policy cycles, noted that "policy-making pre-supposes the recognition of a policy problem" (p. 46) and that all policy solutions frame a policy problem within a value-laden discourse. However, within policy cycles where policy and legislation are revisited and revised, policy learning can "lead actors to select a different view of how things happen" (Zito & Schout, 2009, p. 1104), or in other words, can lead to changing and

aligning beliefs about a policy issue. Subsequently, policy learning can result in re-evaluation of the courses of action that should be taken in support of policy intents and underlying beliefs. In this sense, policy learning as a means to have policy systems re-evaluate beliefs about a policy problem can be a vital catalyst to policy change in service of policy coordination.

Contextual factors. Policy coordination may be enhanced by contextual forces. For example, Wallner (2017) argued that the economic, institutional, and ideational contexts of a policy area influence the favourability of cooperation. That is, cooperation and coordination may be more likely to emerge in an economic downturn, when there is constitutional, fiscal, or organizational change, or when broad ideational change has resulted in a new consensus on a problem definition.

***Economic factors*.** Funding and economics are often intricately woven into the policy context, and access (or lack of access) to funds has an impact on governance structures. In terms of policy coordination efforts, this sometimes means there is a willingness to retain federal funding in historical patterns to support the hegemonic bureaucratic model (White, 2014). Even in cases where provincial education ministers have agreed to shared decision-making in order to implement policies pan-provincially, regional modifications are still made in accordance with the available economic resources aligned to local priorities (Vergari, 2010). In the context of Canadian social and education policy, where provinces (though not First Nations communities) are granted total control of governance and funding dispersal, it is not uncommon for additional federal money to be offered "in exchange for particular programme development with national standards" (White, 2014, p. 175). This can muddy the water of pre-established (provincial) outcomes and cross-sector partnerships. For example, the Early Childhood Agreement in 2000, the Early Learning and Child Care Agreement in 2003, and Public Safety Canada's adolescent

drug programming documents (Public Safety Canada, 2022) are instances in which federal funding was parachuted into existing provincial education policy, resulting in fragmentation to previously determined policy directions (White, 2014).

Political factors. Wallner (2017) argued that partisan politics in Canada's federalist system have the ability to influence how policy sectors are formulated and how coordination is supported. For example, the conservative federal government of 2005 was seen to be "openly hostile" to harm reduction strategies as part of a national drug prevention strategy (Canadian Drug Policy Coalition, 2020). That position thwarted existing harm-reduction strategies and stymied the production of new ones during this time. Alternately, in 2022 the federal Liberal government announced an exemption to federal drug laws in British Columbia as that province worked to support large-scale decriminalization and harm reduction efforts provincially (MacSweeney & Nassar, 2022). Such an exemption provided pathways for justice, health, and social services agencies to work differently with clients around MHSUD and illustrates the ways in which the political context may influence coordination efforts. That is, political mandates have the power to enhance or undermine coordination efforts within the partisan system.

Ideational factors. In a post-covid context, there is a general consensus that youth mental wellness is decreasing, and drug use is increasing (Abramson, 2021). This, combined with additional pressures on resources and growing consensus in the media and public opinion that substance use issues ought to be dealt with as medical and social issues rather than punitive ones, may provide opportunities to bifurcate from path-dependent models of policy segregation. Insofar as Braun (2008) argued that, "moral obligation seems… to be a sine qua non for achieving encompassing political coordination concerning the knowledge space" (p. 292).

Shifting ideational value perspectives on MHSUD may provide an opportunity to reframe policy goals and policy directives towards coordination.

Barriers to Policy Coordination

In the Canadian federalist context, each policy sector works with state and non-state actors to develop policies and procedures, often in isolation of overlapping sectors, and often with competing values and interests (Bakvis & Brown, 2010). As Wallner (2017) noted, this is vastly different from a centralized system in which a hierarchical authority acts as a "coercive enforcer" (p. 418) to ensure cooperation and reduce redundancies. Within this context, often the composition of provincial ministries is not "conceived according to a functional logic, but to a logic respecting power distribution requirements" (Braun, 2008, p. 292). That is, at times, jurisdictions may be intended to support the bureaucratic system itself, rather than supporting coordination of policy or service provision.

Additionally, while decentralized systems may increase the amount of feedback that policymakers receive about policy initiatives (Ruijer, 2012), meaning-making in cross-sector contexts becomes more and more difficult the more policy actors there are (Scharpf, 1997). When dealing with large numbers of stakeholders, as there are in the case of MHSUD, there is a danger of initiatives lacking a shared purpose, resulting in fractured policy implementation across or within sectors (Tamtik, 2017). Though national policy advocacy groups, often funded by the federal government, provide mandates, research, and strategic plans to provincial policy contexts[4], compliance with such mandates is essentially voluntary. Given Canada's "long-standing commitment to preserve and protect provincial autonomy" (Wallner, 2017, p. 425), provincial ministries are generally independent, though federal coordination mechanisms are

[4] For example: Canadian Substance Use Costs and Harms Scientific Working Group, 2018; Canadian Centre for Substance Use, 2020; Cumming et al, 2016; Pan-Canadian Joint Consortium for School Health, 2013.

more prominent in some sectors than others (White, 2014). Policy coordination, thus, provides a pathway to shared goals and visions within multi-level governments and between policy sectors, but in the Canadian federalist context, decisions are built out of an already siloed system, making coordination difficult.

Within such a cluttered landscape, the policies of one jurisdiction can create negative spillovers to other jurisdictions, and therefore a management of interdependencies is necessary to avoid unexpected outcomes to policies (Andreoni & Chang, 2019). In this sense, "tendencies of public sector organizations to protect their areas of interest and avoid policy risks" (Jungblut & Rexe, 2017, p. 52) must be overcome in order to move any meaningful coordination forward. In general, the efficacy of policy coordination hinges upon numerous facets: the investment of involved actors, alignment of their values, the authority of the actors, and the extent to which coordinating bodies have set out collaborative goals and shared data in advance of a collaborative project. Rizvi and Lingard (2009) claim that, "policies are designed to ensure consistency in the application of authorized norms and values" (p. 8). Therefore, collaborative goals are vital in ensuring that policies in multiple sectors are working to achieve similar outcomes, and also to inform the types of service coordination that might be possible in complex organizational systems.

From a hierarchical governance perspective, Wietkorowicz (2001) argued that coordination is not well supported when: (1) budget and planning decisions are made at different jurisdictional levels; (2) there are not clear incentives to align care with partner organizations; (3) there are insufficient resources for investing in information-sharing systems; and (4) there is a lack of trust between organizations. Many of these coordination efforts can be supported by federal and provincial mandates and policy that supports coordination. However, Peters (2015)

argued that, "there is a good deal of evidence that the bottom of organizations develop their own perspectives on policy and may make decisions on criteria that differ from those intended at the top" (Peters, 2015, p. 222). That is, in a multi-level system, the capacities of different sectors and levels of government to implement policies, the discrepancies in belief systems between sectors and levels of government, and the complicated communication between sectors and levels of government become major barriers to coordination.

Coordination of What: Multi-Tiered Systems of Support

In discussions of policy coordination it is important to be clear about what exactly is being coordinated. Certainly, in the scope of MHSUD responses there are an array of policy actions and responses to different levels of need—from primary prevention and universal awareness campaigns, to specialized services and individualized treatment plans. The Multi-Tiered Systems of Support (MTSS) model—also known as the Response to Intervention (RTI) model—is a useful framework to break-down responses and supports in order to identify what levels of needs are supported by policy responses (Ziomek & Heckman, 2019). This model centres around a continuum of supports with the premise that there should be a variety of responses that can be scaled up and scaled down dependent on need. The MTSS model tiers responses and interventions into universal, targeted, and intensive interventions where universal interventions are implemented to support an entire population, targeted supports are catered to 10-15% of the population who need more focused interventions, and intensive supports are focused on roughly 5% of the population who require individualized, intensive supports (Ziomek & Heckman, 2019). Other models of MTSS utilized five or six tiers, but the main premise remains the same: that there are some universal supports (for example, services and resources)

provided to an entire population and more specialized and higher intensity supports are added in response to a spectrum of need. RTI and MTSS have historically been applied to academic interventions in schools, but more recently have been applied to social-emotional programming (Foley, 2019), school attendance (Kearney & Graczyk, 2020), public health (Blewitt et al., 2021), and mental health interventions (Cheung et al., 2009).

MTSS ensures that individuals "receive a continuum of effective, research-based social emotional…supports, instruction and intervention (Foley, 2019, p. 1338). From a policy-analysis perspective, the model allows us to compare the tiered supports that are being offered in particular policy subsystems, which can explicate at which tier(s) coordination gaps may exist. In the case of policy coordination, the MTSS model also offers a framework through which to review catalysts and barriers to coordination at different tiers of intervention. The RTI framework outlines primary prevention (tier one), secondary prevention with an emphasis on individual or small group supports for skill development (tier two); and intensive, strategically tailored individual interventions (tier three) (Ziomek &Heckman, 2019). When looking at coordination mechanisms to support response systems, consideration of what tiers of support benefit from policy coordination can be used to identify system gaps.

The Political Context for Policy Coordination: Canadian Federalism, Multi-Level Governance and Indigenous Governance

In this section, Canada's decentralized federalist governance model will be explored as a site for potential policy coordination to support education. I begin by outlining the structure of Canada's decentralized federalism, including its delegation of decision-making to provinces in education, and its implications for local policy actors. In order to illustrate multi-level policy

coordination mechanisms currently in place, I then explore federal control of Indigenous governance and the emergence of Jordan's Principle as a federal funder for social, health, and educational service provision for Indigenous youth. An understanding of the specific constellation of policy actors in the Canadian multi-sector context paves the way to consider structural opportunities for coordination to support youth with MHSUD.

Canada's Decentralized Federalist Model

Canada's federalist system is built on siloed arenas of decision-making even when addressing cross-sector issues (Papillon, 2012; Verdun & Wood, 2013). Except in the case of Indigenous governance (which will be explored below), this decentralized system operates with the federal government shifting governance of most policy sectors to the provincial governments and maintaining control primarily by determining the amount of money to be transferred (Wood, 2013). In the cases of health, social services, and education—all of which inform MHSUD policy—the constitutional division of powers set out federal and provincial authority over law and policy making for each sector. That is, provinces to administer services with differing levels of federal control depending on the policy sector. For example, Health Canada (HC) (a federal department) has considerable impact on provincial health policy, both by virtue of the fact that the federal government transfers significant funds for provincial health governance, but also because HC utilizes partnerships with provincial health ministries as a means of control (HC, 2021). Alternately, K-12 education and social services (both provincial ministries), by comparison, have no federal ministry directing their work and are constitutionally designed to be controlled provincially. Thus, instead of federal control in these arenas, the federal government exerts some influence through policy papers/positions and grants to support individual initiatives

(White, 2014). Overall, a lack of federal regulations or control mechanisms regarding how policy sectors such as education, health, and social services implement policies in each provincial jurisdiction leads to differences in policy priorities between provinces and between sectors themselves (Vergari, 2010).

Federal delegation of governance to provincial governments. Within Canadian federalism, provincial ministries develop legislation and are in a unique position of being committed to executing federal initiatives and funding via vertical governance mechanisms, but also to co-implementing policy in parallel with other ministries that share policy sectors through horizontal governance mechanisms. For example, in the Canadian context, social services, health, and education policy overlap with individual mandates to support children. The result is that there is possibility for horizontal shared competency across policy sectors [seen, for example, in collaborative frameworks and in co-implemented reports (see Brownell et al., 2015; JCSH, 2009; PSC, 2009)]. At the same time there is also a possibility for redundancies, service gaps, and increased bureaucratic administration (Braun, 2008). Furthermore, while co-implemented initiatives on youth are often developed in policy arenas other than education, the implementation of those policies often happens in schools. Thinking back to the example of Hannah, we can see that even if a policy itself is not co-legislated by education stakeholders, it is often implemented in schools by/with educators. In such a dynamic context, inquiries rooted in opportunities for coordination—for example, into the influence of social and health policies on education in both production and implementation—have the capacity to bring to light horizontal power relationships and also to see which aspects of health and child welfare are under-supported in an educational context.

Provincial governments must therefore work with governance mechanisms vertically and horizontally. Rodon (2014) notes that horizontal relationships in federalist systems must be able to respond to contextual realities. In this way, the multi-level relationships that exist in Canadian federalism can be considered not simply as a system, but as an "*instance* of a specific actor configuration" that changes over time as government and non-government actors change and contextual forces change (Alcantra & Spicer, 2016, p. 33). Voice in a particular policy-making context, made up of a unique configuration of provincial, regional, local, and non-governmental actors, may be unique to the contextual factors at a given moment.

Vertically, federal mandates—for example, through federal directive legislation and funding structures—*can* provide direction to provincial bodies, though this mechanism is uncommon. For example, White (2014) argued that many of the early childhood directives from the federal government in the early 2000s involved federal funding if, and only if, a particular federal program was implemented provincially. While there is currently federal legislation related to MHSUD that provinces must follow (for example, the Canada Health Act), one critique of Canada's federalist system is that often opportunities to take on important directives are missed. For example, in 2019 Witkorowicz et al. argued that the Canada Health Act "could have addressed the growing need for broader health insurance by making coverage for non-physician health and mental care providers… a condition of federal funding transfers" (Witkorowicz et al., 2019, p. 16). Similarly, Bartram and Lurie (2017) suggested expanding the mandate of the Mental Health Commission of Canada (MHCC) to include a monitoring function, or entrusting monitoring to provincial and territorial auditor generals, so that there could be some oversight of service provision and recommendations for coordination. Currently, there is no such mechanism in place. Given Wietkorowicz's et al's (2010) argument that in large urban and large

rural jurisdictions alliance models are reliant on external governance and mandates in order to be successful, there seems to be strong arguments for HC to set out some further guidance with regards to mental health and substance use disorders. That is, a mandate forcing mental health to be coordinated in a similar manner to physical health with increased structure, coordination, and coverage could well be something that could be federally determined, despite a decentralized federal system. While governance in Canada includes horizontal and vertical policy forces, in the case of mental health, there are calls to have a stronger vertical governance mechanisms in place.

Canadian federalism and local, regional, and non-governmental actors. At local and regional levels, provincial ministries work with multiple stakeholders in the policy sector of MHSUD, including unions, school divisions, regional health authorities, school boards, regional social services agencies, local police, local advocacy agencies, local charities, and advocate offices to advance social, educational and health-based policy. Papillon (2011) suggested that the number of independent actors influencing not only regional, but also provincial and federal policy, creates the possibility for change-at-the-ground-level, which is vital to democratic policy change and policy action over time in a federalist system. However, at the same time this aspect of federalist systems presents difficulties with efficiency, insofar as governing becomes more difficult when dealing with multiple actors, agendas, and interactions (Hooghe & Marks, 2003). Sharpf (1997) argued that governing bodies may choose to limit the number of autonomous actors, or the interaction by independent actors, in order to make governing more efficient. However, Rajabiun and Middleton (2013) found that in some instances, inclusion of non-state partners has the capacity to improve efficiency of a particular policy area if non-state actors already have established infrastructures to work towards pre-determined outcomes. For example, a school division may choose to partner with an existing local mental health organization to

support students with mental wellness rather than working alone to develop new initiatives. Thus, in a decentralized model in which nongovernmental actors also have policy input, horizontal dispersion of relationships with non-state actors hold considerable power in governance (Rodon, 2014) but may also further complicate labrynthine systems.

Some scholars (Harlow & Rawlings, 2006; Olsson, 2003) have argued that multi-level frameworks with both governmental and nongovernmental actors produces a danger of accountability deficits. The argument here is that if governments reach out to convenient non-state partners, it may lead to increased bias and lobbying in governance, thereby posing a risk to democratic norms (Harlow & Rawlings, 2006). However, other scholars see the rise and voice of non-governmental actors as a strength of increased democratization of policy process (Conteh, 2013). In the context of Canadian K-12 education, Tamtik & O'Brien Klewchuk (2020) have argued that there has been a "rise in the authority of non-governmental actors including parents and students, to shape the services programs and curriculum content offered by public schools" (p. 2). Similarly, researchers (Busemeyer et al., 2013; Gornitzka & Maassen, 2014) noted that globally, education is becoming more politicized, politically salient, and an embedded element of other public policies (Chou et al., 2017). In the contemporary context, the public also has increased voice in policy governance. For example, newly established provincial Human Rights Commissions provide opportunities for citizens to advocate for change to education-related (and other policy area) decisions. In sum, in an era of increasing access to technology and to knowledge, the number of stakeholders from regional, local, and non-governmental perspectives able to wade into particular policy areas is increasing.

Canadian federalism, globalization, and the policy context. Canada's decentralized federalism means that in most policy areas—including education, health, and social services, as

discussed above—"provinces are the primary decision-makers and service providers and that the federal government enacts only indirect policy control" (laFleur et al., 2021, p. 1). However, despite the decentralized nature of Canada's federalism, the interplay between globalization and education policy cannot be dismissed. Globalization has had a significant impact on state-based education policies, insofar as "policy looks increasingly homogenous in education systems around the world" (Ozga & Lingard, 2007, p. 66). Policy numbers—that is, certain statistics that have been chosen to measure the success of education internationally (Rose, 1999)—have unprecedented strength to assess educational success at the national level. Insofar as increased globalization has been co-constructed with neo-liberal ideals (Schultz & Viczko, 2016), there has been a move to "a conception of education policy as human capital development" (Ozga & Lingard, 2007, p. 68), where performance data is tied to neo-liberal discourses of knowledge economies and a focus on education as a means to meeting economic needs. Often policy numbers within this system do not convey the actualities of local conditions and focus on learning as tradable economy, rather than as a public good. In a competitive international context, it is thus important to note that sometimes local policies are implemented as a means to support policy numbers rather than to support youth themselves (Harvey et al. , 2007), or to support a "normative vision about what educated individuals and active citizens might look like in [a] globalized world" (Ozga & Lingard, 2007, p. 68). In the case of MHSUD policy, for example, hospitalization data for acute mental health care is not standardized, particularly in Indigenous communities, and access to accurate data is limited (Statistics Canada, 2018). This may contribute to systemic racism and policy numbers aiming to declare to the world that our health care system is performing better than it actually is (Gunn, 2016). Furthermore, intergovernmental organizations and supra-governmental organizations such as the Pan-

Canadian Consortium for School Health, UN Convention on the Rights of the Child, and the Organization for Economic Cooperation and Development often make pan-national recommendations that impact schools, but because Canada does not have a federal department of education, pan-national goals are not binding and are often implemented in a fragmented way, as evidenced by "significant variation in student performance across provinces in Canada" (White, 2014, p. 179). Thus, when investigating opportunities for policy coordination provincially and regionally, it is important to consider the effects of supra-national persuasion and the impact of neoliberal ideals often held by the governments.

Canadian federalism and Indigenous governance. It is particularly important that we consider the positioning of Indigenous youth with regards to MHSUD responses, both as part of our commitment to the Truth and Reconciliation Commission's (TRC's) Calls to Action, and to acknowledge the overrepresentation of Indigenous youth in MHSUD prevalence in Manitoba (Kidd et al., 2019). The TRC's Calls to Action have direct calls on federal, provincial and regional governments to be educated about residential schools, understand their impacts, and to move forward policy that supports reconciliation in Canada. In particular, the TRC has called on "child-welfare decision-makers [to] consider the impacts of the residential school experience on Indigenous youth" (TRC, 2015, p. 1). In supporting Indigenous youth with MHSUD, a number of the Calls to Action are pertinent for policy responses moving forward to consider. Those include calls for the elimination of education funding discrepancies on First Nations, closing the gap on languishing health outcomes, including Indigenous knowledges and healing practices in care paradigms, and closing the gaps on the over-representation of Indigenous youth in the child welfare system. Virani and Haines-Saah (2020) argued that health outcomes for MHSUD cannot be considered in absence of understandings of colonialism and of social, educative, and equity

contexts. Thus, it is vital to consider how the TRC has changed the policy context related to Indigenous youth with MHSUD, but also how it ought to continue to change.

Social, health, and educational outcomes for Indigenous youth. In order to discuss how a federalist policy context can work to be responsive to Indigenous youth with MHSUD, it is vital to understand the social, health, and educational positioning of Indigenous (First Nations, Métis and Inuit) youth in Manitoba. Statistically, Manitoba has one of the highest number of children in the child welfare system across Canada with 90% of these children identifying as Indigenous (Government of Manitoba, 2018). Yet, policy—or perhaps, a lack of policy—continues to contribute to languishing outcomes for marginalized Indigenous youth in Manitoba. Blackstock (2022) argued that the "cost of chronic negligence" by the federal government includes the fact that "nearly 60,000 First Nations children… were removed from their homes since 2006 because Canada's deficient public services denied families the chance to recover from the multi-generational harms of residential schools" (p. 2). In 2021, the Canadian Council of Child and Youth Advocates wrote an open letter arguing that, "immediate and long-term actions are required to address the social determinants of health for these children and youth, including adequate housing, elimination of poverty, improvements to infrastructure, and ensuring clean water and food security" (p. 1).

Indeed, the continuous effects of colonialism in Canada and the lasting effects on Indigenous youth in particular (Dhillon, 2017) are key contextual forces when considering the social, health and educational contexts of Indigenous youth. Indigenous youth have been found to have greater adversity in all social determinants of health. That is, the conditions in which people are born, grow, live, work, and age that may either have a positive or negative impact on health (Kidd et al., 2019). Greenwood and de Leeuw (2012) noted that Indigenous youth are:

> born into a colonial legacy that results in low socioeconomic status, high rates of substance abuse and increased incidents of interaction with the criminal justice system. These are linked with intergenerational trauma associated with residential schooling and the extensive loss of language and culture. (p. 383)

Despite these lasting impacts of colonialism, child welfare, health, and education are underfunded on reserves (Blackstock, 2016). Indigenous youth are also over-represented in socially located health outcomes, including the homeless population, which can be seen as a "product of a breakdown of healthy Indigenous relationships brought to bear by historic processes of colonization, such as land displacements, disconnection from identity, loss of culture, linguicide, democide, and a loss of Indigenous cosmology" (Kidd et al., 2019, p. 167).

From a healthcare perspective, Indigenous youth face "alarming health inequities, subpar access to health care, and culturally discontinuous services" (Allen et al., 2020, p. 1). The World Health Organization has called for closing the gap on health inequities for Indigenous peoples, but "the reality remains that Indigenous children, youth and their families live with disproportionate burdens of ill-health" (Greenwood et al., 2018, p. 1645). Indigenous youth suicide rates are five to seven times the suicide rates for non-Indigenous youth in Canada (Government of Canada, 2018), and "suicide and self-inflicted injuries are the leading cause of death among First Nations youth and adults" in Canada (Barker et al., 2017, p. 5). Furthermore, substance use disorders among Indigenous youth are higher than the national average, "which can be attributed to the legacies of colonization, which alienated Indigenous populations, suppressed their cultural beliefs and practices, created isolated reserves, and geographically segregated Indigenous populations in urban areas" (Maina et al., 2020, p. 6). Indigenous youth also have higher rates of infant mortality, tuberculosis, HIV, injuries and deaths, middle ear

infections, childhood obesity and diabetes, dental issues, increased exposure to environmental contaminants including tobacco smoke (Greenwood & de Leeuw, 2012; Kidd et al., 2019). In general, both historical and contemporary colonialist policies have dissolved cultural continuity and unfavorably shaped Indigenous healthcare outcomes (Kim, 2019).

In addition to the evidence outlining comparatively poor healthcare outcomes for Indigenous youth, that *access* to healthcare "is neither equal nor equitable among all Canadians, and Indigenous peoples in Canada tend to have more difficulty accessing healthcare services than non-Indigenous Canadians" (Horill et al., 2018, p. 2). Indigenous children have lower rates of vaccination and lower rates of being able to access a doctor (Greenwood & de Leeuw, 2012). A lack of availability of services and healthcare providers to on-reserve First Nations families is a primary barrier to Indigenous youth accessing care, as is limited access to screening to diagnose emerging issues (Lavoie et al., 2016). Without access to care on reserves, accessibility of urban care options become paramount. However, waitlists, financial and insurance barriers, transportation barriers, and communication barriers then become limitations to accessibility of health care services (Horrill et al., 2018; Scheim et al., 2013; Schmidt, 2009; Stewart et al., 2017). Furthermore, Horrill et al. (2018) noted that, "Lower levels of education are associated with poorer health… among Indigenous peoples in Canada; one underlying argument is that lower education results in a lack of awareness regarding early detection and preventative care, which is a barrier" to accessing healthcare (p. 4). Additionally, marginalized youth are at elevated risk for mental health difficulties as they encounter barriers to engagement with MHSUD services. Stigma, shame, and "past negative experiences with… systems of care contribute to distrust of service providers" (Sapiro, 2020, p. 3) and creates psychological barriers which exacerbate accessibility concerns. Despite changes to health care service provision for

Indigenous youth in recent years there are still serious ongoing health inequities being perpetuated (Kamran, 2021).

Educational outcomes for Indigenous youth are languishing in comparison to their non-Indigenous peers. On reserves, the federal government funds Indigenous education at a level 30% less than provincial education models (Dart, 2021). In Manitoba, the proportion of Indigenous youth who do not complete high school is 50%, compared with 10% for non-Indigenous students (APTN, 2021). Furthermore, Indigenous students indicate that in their school encounters with peers and teachers they are regularly exposed to racism (Bailey, 2020; Schissel & Wotherspoon, 2003). Indigenous students are often met with a decision to attend schools on reserves (funded federally) or schools in urban areas (often with federal transfer of funding), however, insofar as schools on reserves in Manitoba do not offer full K-12 programming, students are often forced to leave their families and attend urban schools in unknown communities to continue their studies (Government of Canada, 2017). Indigenous schools on reserves, funded by the federal government are underfunded and under-resourced (Dart, 2022). Furthermore, there is no federal legislation mandating Indigenous voice in school-based governance, so communities themselves lack control of education programming (AFN, 2012). In sum, there is a perpetuating lack of culturally appropriate care for Indigenous youth and families in Manitoba across fields of health, child welfare, and education (Hare & Pidgeon, 2011).

Jordan's Principle. Rather than falling under provincial ministries, Indigenous health, education, and social services are funded by the federal government. Indigenous First Nations throughout Canada have long advocated for control of education, health, and child welfare, but the federal structure has been slow to change (Gerlach et al., 2020). This context of underfunded

and poor health, child welfare, and education outcomes for Indigenous youth has prompted calls for change. Jordan's Principle—a federally funded initiative intended to support gaps in service provision for Indigenous youth who do not have access to medical, social, or educational resources that belong to other Canadians (Blackstock, 2016)—is another policy actor which has entered the constellation of MHSUD supports. I explore here the history of Jordan's Principle, concerns with the approach it takes to service provision, and implications for policy coordination.

Jordan's Principle was originally passed in Parliament in 2007 as a "child-first principle intended to resolve jurisdictional disputes within, and between provincial, territorial and federal governments concerning payment for services to First Nation children when the service is available to all other children" (Blackstock, 2012, p. 368). Jordan's Principle was named after Jordan River Anderson, a child from Norway House Cree Nation, Manitoba, with significant medical needs, who was kept in hospital while federal and provincial governments disputed over which level of government was responsible for paying for his home care. Jordan died in hospital in Winnipeg while the dispute went on and was never able to live in his home community. However, even after parliament passed Jordan's Principle, concern with equity of medical care continued. Jordan's Principle was enacted by bilateral agreement—a non-legislative response—and operationalized between the federal government and provinces by 2012. Consistent with the Canadian federalist context, agreements between provinces were inconsistent, and the same level of coordination was not available in all provinces. However, the system itself was met with significant concerns from critics: Jordan's Principle only applied to First Nations children who were ordinarily residents on a reserve. It could only be accessed by youth with multiple disabilities who required numerous service providers and could only be enacted if there was a

dispute between the federal government and the provincial government, based on normative standards of care (Blumenthal & Sinha, 2015). Critics argued that Jordan's Principle, in the way it was enacted, did very little to overcome equity concerns for Indigenous youth. Eligible population and operational definitions were narrow, it failed to identify consistent mechanisms for scalability, it excluded First Nations people from administration, and lacked transparency and accountability mechanisms (Blumenthal & Sinha, 2015).

In 2016, the Canadian Human Rights Tribunal (CHRT) ruled that the Federal Government was not implementing Jordan's Principle adequately. There was a move from identifying jurisdictional disputes as a mechanism to accessing Jordan's Principle support, to identifying jurisdictional gaps. In the same 2016 ruling, the suggestion was made that substantive equality—the belief that individuals from one group should not be treated less favourably than those in another, and that inequality should not be perpetuated—should be held as a primary catalyst for decision making (Sinha et al., 2021). However, it was not until 2018, when the federal government was again found to be noncompliant with the CHRT ruling, that significant reforms were undertaken by the federal government. Since 2018[5], Jordan's Principle has been implemented by the federal government with a goal of substantive equality, meaning, "services needed to provide First Nations children with the same outcomes as other children, taking into account the disadvantage that First Nations children experience" (Kamran, 2021, p. 280). In its current iteration, and based on substantive inequality, Jordan's Principle is intended to support First Nations youth on or off reserve with a variety of medical, social, and educational supports in a timely manner, specifically when there are existing funding gaps (Kamran, 2021). Within

[5] This legal obligation of the federal government first enacted in 2007 was challenged by the Canadian Human Rights Tribunal (CHRT) in 2016, and then in 2018 the federal government was found to be noncompliant with the CHRT's ruling, prompting reforms.

each province, "focal points"—regional employees of the federal government—have been identified for specific regions and youth. Families and service providers are able to access Jordan's Principle supports through these focal points (Sinha et al., 2021). Furthermore, the Jordan's Principle Child First Initiative includes funds for "enhanced service coordination" (Gerlach et al., 2020, p. 21). These funds intended to help maximize First Nations children's health, social, and education needs by leveraging and extending existing provincial and regional frameworks and service provision networks.

Jordan's Principle is a policy framework intended to provide funding to support Indigenous youth and families to access existing provincial/regional service providers. In this sense, Jordan's Principle can be regarded as a mechanism of (limited) federal policy coordination insofar as it coordinates and expedites funding to social, health, and educational service providers. While there have been positive outcomes for Indigenous youth as a result of Jordan's Principle, particularly when service coordination models are implemented by regional and provincial governments to work with Jordan's Principle (Gerlach et al., 2020), critics have argued that it represents a "projectified" approach to policy. That is, instead of a robust policy response which is designed to provide universal and proactive supports to need, it instead responds reactively on a case-by-case basis (Sinha et al., 2021). Furthermore, Jordan's Principle contributes yet another policy-actor to an already cluttered policy landscape, complicating existing service provision and taking assimilationist responses to Indigenous issues (Chambers & Burnett, 2017).

As a federal mechanism to fund health, social, and education costs for First Nations youth, Jordan's Principle essentially works as a service-funding body in absence of integrated policies to support Indigenous youth. Thus, critics note that it does nothing to fix systemic

inequities within governance structures and rather adds another layer of bureaucracy to an already complex policy landscape (Sinha et al., 2021). Furthermore, there has been concern with the lack of Indigenous voice in administering and planning for Jordan's Principle. For example, in 2016, when the CHRT ruled that the federal government reform application of Jordan's Principle across Canada, the Assembly of First Nations (AFN) penned a comprehensive report to advocate for inclusion of Indigenous governments in planning for and administrating Jordan's Principle (2015). The AFN called for consideration of Indigenous infrastructure development when discussing social, heath, and education issues (Blackstock, 2016). Even so, the initiative continued to be controlled through the federal government in a project-based system.

Critics continue to argue that Jordan's Principle places the responsibility of action on the caregiver, which removes agency from First Nations in developing and implementing fundamental change, but also positions the Principle as a reactive paradigm. This puts the onus on individuals for launching change on a case-by-case basis, rather than system- wide level (Gerlach et al., 2020). This project-based paradigm is a far cry from the AFN's (2015) call for service delivery and coordination where "First Nations lead, design, and deliver strategies" (Gerlach et al, 2020, p. 32). Critics have argued that substantive equality is not yet achieved by Jordan's Principle (Sinha et al., 2021) and in the context of policy-coordination, Jordan's Principle brings the federal government back into the regional/provincial field of decentralized federalism. That is, while the intent is to coordinate funding to Indigenous youth services, Jordan's Principle in its current iteration complicates policy coordination provincially and locally and separates decision making from First Nations themselves.

The Social Context for Policy Coordination: Historical Responses to MHSUD, the Shifting Ethical Landscape, and the Case for Cross-Sector and Restorative Responses

Given that MHSUD is an ethically charged issue, it is important to understand the social context associated with MHSUD supports enacted in schools, and how changes in the ethical landscape have shifted the types of supports available for youth with MHSUD stemming from framing of the issue. In this section, I first provide a review of historical zero-tolerance school-based responses to MHSUD in schools and explore the shifting ethical landscape of responses to MHSUD. I then examine tiered responses to MHSUD including recent moves to preventative, restorative and cross-sector supports for youth. Finally, I review some best-practices in MHSUD response, which are increasingly non-punitive, cross-sector and multi-dimensional responses.

Historical Zero-Tolerance Responses to MHSUD in Schools

Historically, "much of drug policy [has been] driven by moral panic, political expedience and populist rhetoric" (Stimson et al., 1999, p. 319). This has resulted in coercive school-based drug policies and drug education programming in schools, whereby the primary goal has been dissuading young people from "choosing" the dangerous path of drugs (Blackman, 2004). Such policies are enacted in two primary ways: (1) through discourses used in (proactive) drug education programming—for example, drug education programs which construct young people who use drugs as irrational individual failures "who have failed to adhere to the one rational choice provided in drug education: saying no to drugs" (Farrugia, 2014, p. 665); and (2) through the responses that take place (reactively) following incidents with drug use or dependency, which in the school setting are largely disciplinary responses legislated through codes of conduct (Mallet, 2016). Some of these disciplinary responses are rooted in zero-tolerance policies, which

overarchingly utilize suspension as a punitive response to student infractions, including drug and alcohol use (Winton, 2012).

McIntyre et al. (2019) noted that, "zero-tolerance policies were first developed… during the late 1960s and early 1970s… to combat narcotics trafficking" (p. 335) before being applied to the school system. Simply put, "proponents of zero-tolerance argued that perpetrators make a rational, free will choice to take part in delinquent acts and that harsh punishments [are] necessary to effectively deter these world-be offenders from taking part in unwanted behaviours" (McIntyre et al., 2019, p. 337). North American national and regional zero-tolerance responses to drug use were further bolstered by a 1998 UN General Assembly Special Session, which proclaimed the necessity of a strategy to prohibit illicit drugs through zero-tolerance policies rooted in criminal justice systems globally (Csete et al., 2016). In the same way that "the pursuit of drug prohibition [then] generated… the excessive use of incarceration as a drug-control measure" (Csete et al., 2016, p. 1429), schools' framing of drug use as a disciplinary event has often shifted discourses in schools from support to blame (Noguera, 2003).

More recent discourses in schools with regards to substance use have been rooted in ideals of safety. The view that students involved with drugs are a danger and ought to be removed from the school, "constructs a singular and rigid narrative of drug use, ignoring young people's complex subjectivities and lived experiences with the potential result of alienation from health messages" (Farrugia, 2014, p. 668). Furthermore, insofar as the primary role of the school system is to educate (and not to sentence students in a criminal justice model), zero-tolerance responses supported by discourses of safety "further alienate those students already marginalized in the public school system. This serves to exacerbate negative schooling experiences, including lack of school success" (Colorado & Janzen, 2020, p. 4). Engel and Silver (2001) argued that

negative experiences, including encounters with zero-tolerance policies result in a "criminalization process…propel[ing] some youth into violence and gangs due largely to the negative experiences in the educational system" (p. 175). Consequently, in the contemporary education system, there has been a growth of an "education-incarceration relationship" that takes place when schools identify "risk factors" as moralistic judgments, rather than as symptoms of languishing mental health, physical health or life circumstances (Portillos et al., 2012, p. 172). This education-incarceration relationship has been described as the "school-to-prison pipeline" (Christenson, 2012). The processes of criminalizing youth carried out by "disciplinary policies and practices within schools that put children into contact with law enforcement" (Cole, 2018, p. 1) often further alienate youth from the education system.

Youth engage in drug use and drug dependency for a variety of reasons; in some cases, it is out of curiosity or criminal activity, but it can also be a form of self-medication in relation to mental health, physical health or trauma, and/or as an escape from negative life circumstances (Mate, 2008). Thus, a solely disciplinary response does not adequately support the whole child. Stimson et al. (1999) noted that in public health, "there are guides on assessing and responding to the adverse health consequences associated with [drug use and that it is important to] properly identify and target interventions and to develop interventions that are both appropriate and resource effective" (p. 319). In this sense, it follows that education, as a policy sector, can learn from and turn to health and social work practitioners and policies as experts in advising school-based responses to drug use rather than acting in isolation. Wietkorowitz et al. (2019) indicated, from an addiction science perspective, that substance dependency is not a destination that one arrives at – there is not a direct line at which point someone becomes an "addict." Rather, there is a spectrum of dependency with people moving towards more risky behaviours, which require

varied (medical, social, vocational, mental health) responses. School-based drug and alcohol policies ought, then, to be aligned with research from public health, mental health, and social work to ensure that school-based incidents of drug use are dealt with in an educative and supportive model.

Furthermore, solely disciplinary responses run the risk of exacerbating negative stereotypes and stigma. Stimson et al. (1999) noted that, "political priorities may take precedence over public health imperatives" (p. 319) in the case of the highly moralized issue of drug use and abuse. Stigma and a lack of resources for treatment are significant barriers to adolescent treatment (Wisdom et al., 2010) and contribute to drop-out rates in youth (Baker et al., 2020). Research found that there are far more significant "benefits of undertaking a harm-reduction approach" (Baker et al., 2020, p. 34), which focuses on health-care models of support, rather than undertaking punitive responses of placing blame.

Shifting Ethical Underpinnings and Multi-Sector Understandings of MHSUD

In recent years, responses to MHSUD in the Canadian context have shifted tremendously, moving beyond a "tough on drugs" mentality. Depending on the policy context, discussions of youth substance use may be rooted in discourses of health care provision, child welfare, or social supports. Different sectors may hold different ethical underpinnings, ranging from the need to enhance restorative approaches, to the need to return to zero-tolerance responses. For example, public health responses in North America have been intended to mitigate social and individual harms associated with stigma and drug use (Watson, 2019) and may not align with justice policies that criminalize substance use and school-based policies rooted in ideas of zero-tolerance (McIntyre, 2019). Research and public awareness campaigns over the last two decades

have focussed on harm-reduction efforts, de-criminalization of drug use, the documented link between substance use and mental health, and calls for restorative discipline rather than zero-tolerance paradigms (Strike & Watson, 2019). Within this context, policy learning has prompted social actors and policy stakeholders to shift conversations from blaming youth, to working to develop a better sense of at-risk youth and to link MHSUD research with trauma and holistic models of youth support. However, the shift in literature and research to see substance use as an indicator of trauma and languishing mental health (Kirsch et al., 2020) has not yet been fully accepted as a social understanding, given the stigma that youth with substance use disorders still face (Wietcorowicz et al., 2019). This section explores some of the broader social initiatives around MHSUD that contribute to changing paradigms for response to youth MHSUD, including evolving changes in values and norms for MHSUD responses.

Harm-reduction efforts and socio-ecological models of health. In recent years, there have been calls to reform responses to substance use to embrace on harm-reduction models of care. Whereas decriminalization aims to remove criminal charges for illicit drug use and possession in order to improve help-seeking behaviours (Strike & Watson, 2019), harm reduction can be considered "policies and programs that aim to help people who use drugs be safer and healthier" (Hyshka et al., 2019, p. 142). Canada has been seen as one of the global pioneers in harm reduction efforts (Riley et al., 2012), though these efforts have been inconsistent across Canada (Carter & McPherson, 2012; Hyshka et al., 2019). Calls for consideration of harm-reduction approaches to substance use were first raised by the liberal federal government in the late 1990s, though the federal government at this time was also criticized for not providing enough additional funds to the provinces to fund such endeavours (Hyshka et al., 2019). In 1998, the federal government facilitated the implementation of a harm-reduction pilot site in

Vancouver, propelling Vancouver and British Columbia to the front of progressive and non-punitive responses to drug use in Canada. Recently, Alberta and Ontario have also begun implementing harm-reduction policy at regional and provincial levels (Smith, 2022).

The hope behind many of these programmatic changes involves "framing drug use as a socio-ecological health issue "instead of a criminal one in the hopes people will avail themselves of health services without shame or fear" (Virani & Haines-Saah, 2020, p. 162). Socio-ecological health is a "framework to account for the reciprocal interaction of individual behaviours and the environment in the development" of particular disorders and health behaviours (Willows et al., 2012). In a socio-ecological understanding of health, relationships between an individual's personal traits (for example, health, attitudes, and behaviours) and one's contextual factors (for example, social, cultural, community, and physical environments) are examined holistically (Swinburn et al., 1999, Willows et al., 2012). That is, there is a willingness to consider the intersectionality of multiple factors in assessing MHSUD needs and responses in a socio-ecological model.

In many cases, policy learning processes, conceptualizing MHSUD as rooted in health care paradigms and socio-ecological models of health, have resulted in policy and structural changes, though those changes are also specific to particular jurisdictions. For example, British Columbia launched a Ministry of Mental Health and Addictions (BC/MMHA) in 2017 and Manitoba followed suit in 2021 with the Ministry of Mental Health and Community Wellness (MB/MMHCW). It is noteworthy that "addictions" is absent in the ministerial title in Manitoba which suggests that there still may be stigma associated with addiction in the Manitoban context. In 2020, the Office of the Provincial Health Office in British Columbia made a public call for

decriminalization of narcotics in the province, though there have been no such formal calls in Manitoba.

In sum, despite a decades-long history of socio-ecological understandings of health, there continues to be confusion about policy and legislation related to non-punitive drug responses (Hyshka et al., 2019). For example, in the context of 30 years of policy-advocacy related to consideration of MHSUD as a socio-ecological health issue, Hyshka et al. (2019) undertook a review of formal policies, including statutes, regulations, strategies, documents, and other formalizing text related to harm reduction. They found that most policy Canada-wide was rhetorical, inconsistent across the country, and did not necessarily provide clarity of policy action for policy makers or service providers to inform socio-ecological or harm reduction models of MHSUD. Furthermore, the legalization of marijuana in 2018 had considerable impacts on discourses about drug use in Canada. Protecting youth from harm has been primary argument against legalization (Haines-Saah & Fischer, 2021), despite data that shows that abolitionist and/or punitive approaches and responses to MHSUD lead to fewer help-seeking behaviours (Srike & Watson, 2019).

In the last few years, media (for example, The Globe and Mail, 2019), along with drug policy advocates (for example, Canadian Drug Policy Coalition, 2020), have argued that addiction ought to be seen as a health problem, not a criminal law problem. At the same time, there has also been considerable policy advocacy taking place by mental health advocates, arguing that "medical approaches that do not account for social or structural factors potentially entrench stigma and further disempower people who already experience diminished agency" (Virani & Haines-Saah, 2020, p. 163). That is, health based MHSUD responses have begun to catalyze socio-ecological health approaches.

Emerging understandings of trauma and MHSUD in youth. In recent years there has been significant research into the effects of trauma on youth development in general, and on mental health development in particular. Given the intergenerational trauma that has been explicated through the Truth and Reconciliation Commission, it is important to consider the ways in which historic and current social experiences of youth, rooted in colonization, have contributed to an over-representation of Indigenous youth MHSUD. The social and ecological positioning of childhood trauma reinforces that MHSUD cannot be considered only a health issue – it is a social issue and as well as an equity issue (Drabble et al., 2013). The word "trauma" is used in both clinical diagnoses and in everyday discussions of negative life experiences. Kirsch et al. (2020) defined childhood trauma as experiences that cause "early life stress … [due to] exposure to adverse child experiences" (p. 31) including maltreatment, neglect, or household dysfunction. Early life stress is now understood as a "major risk factor for a multitude of psychiatric and medical disorders" (Kirsch et al., 2020, p. 31). In particular, there is significant research documenting how individuals with trauma histories and associated mental-health disorders are far more vulnerable to developing substance use disorders. Psychological distress in early development alters brain development and diminishes ability to cope with emotions leading to vulnerability to substance use dependencies (Drabble et al., 2013, Kirsch et al., 2020; Perry & Pollard, 1998; Quinn et al., 2021). Studies focusing on adverse childhood experience data find strong correlations between childhood trauma and addiction (Drabble et al., 2013). Trauma-based internalizing and externalizing disorders are associated with a broad range of substance misuse outcomes (Quinn et al., 2019) and "brain changes associated with mood and anxiety disorders increase vulnerability for problematic substance use" (Kirsch, et al., 2020, p. 37). A 2020 study on adolescents and substance use found that "adolescents with substance use

disorders were more likely to report traumatic events… more likely to suffer from PTSD following traumatic events… and more likely to fulfill the diagnostic criteria for PTSD compared to the general adolescent population" (Basedow et al., 2020, p. 559).

The unique developmental characteristics of adolescence complicate comorbid trauma-related mental illness and substance use in youth. While impairment in utero or in childhood causes a "cascade of dysfunction [that] can disrupt normal development… Stress during adolescence may have an especially robust impact on substance use outcomes" (Kirsch et al., 2020, p. 32). Importantly, in adolescence, substance misuse has the ability to alter gene expression, "ultimately leading to more and longer mood episodes over time" (Kirsch et al., 2020, p. 37). Particularly in adolescence, when experimentation with substance use is socially expected, many teens may engage in substance use or misuse "through dysregulated impulses, a victimized child may engage in impulsive or risky behaviours because of affective instability and attempts to self-soothe" (D'Andrea et al., 2012, p. 193). In general, trauma increases risk for MHSUDs "and is associated with a more severe disease course, characterized by earlier onset, greater craving and relapse, treatment resistance and greater comorbidity and suicidal behaviour" (Kirsch et al., 2020, p. 39). The unique positionalities of adolescents "underscore calls to address undiagnosed, untreated psychological and behavioural issues among those with a history of trauma as a public health priority" (Quinn et al., 2019, p. 215). That is, MHSUD care must also be considered trauma care when working with youth.

Barriers to care for youth MHSUD. There has been significant media attention on substance use treatment in the last decade, a declaration of an opioid crisis and the Mental Health Commission of Canada's (MHCC) (2016) Framework for Action vowing to reduce wait times for mental health and addiction services. Yet access to MHSUD care is still a primary barrier to

substance use treatment. Research shows that accessibility—the ability to physically attend centralized office appointments, find transportation to appointments, or the ability to set-up appointments with care providers—is a primary barrier documented by service providers and youth/families in the literature, followed by lack of ability to pay for care (Connors et al., 2021; Hanson et al., 2018; Krausz et al., 2013; McIntyre et al., 2017; Racine et al., 2020; Scheim et al., 2013; Schmidt, 2009; Stewart et al., 2017). This is noteworthy in that, while Canada's medical system is touted as a universal system, mental health care in Canada generally requires insurance or out-of-pocket care (Mulvale & Hurley, 2008). Furthermore, Schmidt (2009) argued that the vertical, centralized nature of existing mental health supports in Canada contributes to access barriers because the system is built on patients working with a primary care provider to access general supports and then be referred to more specific supports. Often specialists are outside the community and the onus is on the patient to access supports in a very regimented, specialist-driven model. This effectively removes supports and knowledge from the cultural underpinnings and community values of local jurisdictions (Schmidt, 2009).

Social and cultural barriers to integrated treatments are also primary barriers for youth. Both social and family-based stigma (Krausz et al., 2013; Schmidt, 2009; Stewart et al., 2017) and lack of culturally appropriate and/or community-based supports are primary barriers to care (McIntyre et al., 2017; Scheim et al., 2013; Stewart et al., 2017; Waddell et al., 2021). In particular, Indigenous people in Canada have difficulty obtaining care involving traditional teachings, ceremony, and access to Elders (McIntyre et al., 2017; Scheim et al., 2013). Western-based interventions often do not share Indigenous ontologies, separating youth from potential supports due to lack of shared worldviews. Given that incorporating Indigenous healing practices into Indigenous mental health care is central to the Truth and Reconciliation Commission of

Canada's Calls to Action research (Sanzone et al., 2019), paving the way for successful integration of Indigenous perspectives in MHSUD care, is vital.

Policy Coordination for Tiered, Restorative, and Cross-Sector MHSUD Supports

Given understandings of socio-ecological health, models of care which are rooted in policy coordination—either at the service coordination end of the spectrum or the policy integration end of the spectrum—for youth are vital but tend to have inconsistent implementation and accessibility. Roughly five percent of the Canadian population suffers from co-occurring mental health and substance use disorders (Center for Addiction and Mental Health, 2021). As many as 35-50% of youth with co-occurring mental health and substance abuse disorders do not (or cannot) access formal care (Wictorowicz et al., 2019). Co-occurring disorders result in increased rates of relapse, hospitalization, and morbidity as compared with single diagnoses (Wictorowicz, 2019). There is significant evidence that substance use disorders escalate and develop more quickly in adolescence than they do in adulthood (Chen et al., 2009), that habituated behaviour during this formative time can develop into long-term patterns (Mirlashari et al., 2020), and that mental disorders are a barrier to substance use recovery unless co-occurring disorders are concurrently addressed (Hadland et al., 2018). However, despite this data, "historically, systems serving individuals with co-occurring disorders (such as: trauma, mental health issues, health problems, and substance use disorders) have been characterized by compartmentalization, fragmentation, and a tendency for systems to operate independently from one another" (Drabble et al., 2013, p. 17). Integrated treatment supports and interventions during the adolescent years are paramount because this is when brain systems are being developed and wired and youth are more vulnerable to potential substance dependency (Chambers et al., 2003).

While “adolescence mark[s] periods of rapid development and while high brain plasticity during this time increases susceptibility to the effects of stress, it also marks a critical window of intervention” (Kirsch et al., 2020, p. 40). In this context, integrated treatment can be differentiated from sequential and parallel treatment. Integrated approaches are intended to respond to co-occurring conditions within the same treatment mandate, thus showing the best outcomes (Wiktorowicz et al., 2019).

Integrated responses to co-occurring conditions also need to consider the unique social and educational contexts of youth. For example, there are higher rates of substance related problems and mental health disorders in youth in foster care and with social services involvement than there are in the general population (Heradstveit et al., 2020). Furthermore, Barnert et al (2020) argued that youth with involvement in the justice system have notably higher mental health, physical health, and substance use dependency risks than their same age peers and that there is a critical opportunity for intervention in working with youth with limited justice involvement. In schools, youth with substance use disorders are often met with disciplinary responses, including suspension, which further remove youth from social-emotional and academic supports (Blackman, 2004). Virani and Haines-Saah (2020) argued that positioning MHSUD as a health isssue, without consideration of social or equity issues is “inconsistent with the lived experiences of people using drugs” (p. 163). Because of the multi-sector positioning of youth, policy responses to co-occurring conditions need also to be multi-sector.

In general, co-occurring mental health and substance use disorders are met with fragmented and multi-sector systemic responses (Esposito-Smythers & Goldston, 2008). That is, youth may be referred to separate “specialists” to address separate substance use, social/familial, academic, vocational, and mental health concerns. Those may be inefficient, may leave patients

with conflicting messages regarding treatment, and may add social barriers to recovery by requiring a patient build therapeutic alliances with multiple treatment providers. In this way, coordinated services and integrated treatment models are vital for supporting youth on their healing journeys. In multifarious mental health diagnoses, treatment options have often focussed on treating individual symptoms within a constellation of mental health issues (Denton et al., 2017). Similarly, policy-responses to substance use are often single-sector (for example, health policy distinct from education disciplinary policies and justice policies). The development of cross-sector therapies may provide a pathway forward to policy coordination and collaboration.

Models of care that bring traditionally separate services together into one community-based setting are often in the best interest of youth, service-providers, and policy makers in that coordinated service models can simplify access and reduce administrative redundancies (Settpani et al., 2019). In many cases, youth with co-occurring disorders "were found to be treated for the same problem by numerous sources, making coordination of their services an important issue" (Wiekorowicz, 2001, p. 4). Service coordination with integrated service models "provide a single-entry point to access a variety of services by coordinating medical care with allied community healthcare and social services" (Wiekorowicz, 2001, p. 3). That is, there may be cases where local level service coordination can be implemented with effectiveness, even in the absence of regional, provincial, or federal coordination mandates. From a policy coordination perspective, alliances between existing regional or local actors at the service provision level are more common, though actors tend only to enter into a service alliance if it is advantageous for both of them. However, in a federalist system, alliances can best be spurred on by government recommendations, mandates, and legislation. For example, the MHCC has called for enhancing and developing school-based mental health services through directed onsite programming and

collaboration with primary care providers and specialty health care providers (for example, child psychiatrists, mental health therapists, and family therapists) (Kutcher & McLucky, 2010). This recommendation requires some type of policy integration model, otherwise schools are in the difficult position of being asked to remove zero-tolerance policies and replace them with social, cultural, and health care supports without partners in those particular sectors.

Multi-tiered systems of supports as a cross-sector framework. In order to provide programming for youth MHSUD that can effectively "identify and provide appropriate supports to all students when they need it" (Foley, 2019, p. 1339), Multi-Tiered Systems of Supports (MTSS) can be used to address MHSUD challenges and ensure that system responses match the need (Froiland, 2014). MTSS take the form of universal, targeted, and intensive interventions and supports and as a framework, MTSS can be used to assess if existing services are able to span a spectrum of need. In the context of MHSUD, universal interventions serve as primary prevention and public awareness interventions. Targeted supports are aimed at 10-15% of the population who need additional interventions or programming despite universal strategies. Intensive supports serve the roughly 5% of individuals who require strategically-tailored, individualized supports (Ziomek-Daigle & Heckerman, 2019).

While Canadian schools have made significant strides to providing multi-tiered systems for MHSUD supports in schools (Chafouleas, et al, 2020), school support systems are not able or intended to independently support many targeted and intensive treatment options. Working hand-in-hand with parents, social workers, crisis response teams, and primary-care physicians to find appropriate referrals is essential (Reinberg & Fefer, 2017). However, schools and parents alike continue to face barriers in having youth access health-based treatment for co-occurring mental health and substance abuse disorders (Filges et al., 2018). Access to supports is complicated by

Canada's federalist system in which multi-level governance and cross-policy contexts tend to take siloed approaches in which health policies, social policies, justice policies, and education policies in response to drug use may not align (Esposito-Smythers & Goldston, 2008), even though research indicates that interdisciplinary responses best support youth wellbeing (Drabble, Jones & Brown, 2013).

There is an admission across the education system that students who have significant MHSUD needs "pose a serious risk to themselves, disrupt classroom environments and challenge school safety and routine" (Ziomek-Daigle & Heckerman, 2019, p. 28). Additionally, there is an acknowledgement that schools face challenges to simultaneously offer safe and positive school climates, prepare students for life after graduation, and acknowledge social complexities (Ziomek-Daigle & Heckerman, 2019). With the admission, then, that zero-tolerance polices do not work, schools find themselves struggling to "identify and provide appropriate supports to all students" through general education processes and policies (Froiland, 2014, p. 1339) and require coordination models to effectively support MHSUD as an indicator of socio-ecological health, and not solely an educational issue. Next, I explore current progress and best practices for universal, targeted, and intensive cross-sector and multi-tiered responses rooted in socio-ecological health perspectives.

Universal supports: School-based primary prevention programs. Given contemporary understandings of MHSUD, access to universal education, and a will to have prevention programming in schools, most public schools have some component of mental health and drug education in Canada. School-based primary prevention programs that link health outcomes with the service delivery of the education system for substance use have been cited in the literature for some time as having the potential to enact strong effect (Botvin & Griffin, 2007). However, in

Canada this primary-prevention education modality seems to lack fidelity and consistency with implementation. In Manitoba, preventative drug and alcohol education is delivered through health curricula (which, at grades 9-12 is embedded in the Physical Education curriculum) (Manitoba Education, 2000). In other provinces, program reviews have led to more robust, school-wide preventative programs (as noted in Dell et al., 2013) rather than curriculum-based ones. Therefore, it seems that in the absence of federal or inter-provincial policies regarding drug education, preventative programming takes different shape in different jurisdictions. Though there is comparative research regarding effective drug education programming dating back decades (see Tobler & Stratton, 1997), there seems to be a lack of coordination with regards to robust drug prevention programming in Canada. There is room for some comparative analysis and recommendations regarding what types of drug education and in what modalities are most effective. Filges et al.'s (2018) were concerned with "the significant gap between the number of young people classified in need of treatment and the number of young people who actually receive treatment" (p. 2). Effective primary prevention/universal interventions also offer potential foundations for multi-tiered systems of support to triage and refer students to higher levels of care (Dell et al., 2013). Given that Manitoba's health curriculum has not been re-assessed since 2000 and drugs and alcohol are only mentioned in Manitoba policy and curriculum documents, (a) in the health curriculum, and (b) punitively, there is a need to revise and revisit policy and preventative substance use education in Canada.

Targeted and intensive supports: Promising-practices of current restorative, cross-sector approaches in Canada. There are multiple evidence-based, cross-sectorial, and integrated treatment options described in the research that would benefit from, and in fact require, cross-sectorial supports. Filges et al. (2018) noted that in North America roughly 90% of youth

substance use treatment is outpatient treatment, and that within this treatment modality, there are high rates of treatment drop-out and post-treatment relapse. Recently, there has been a move to utilize treatments for youth MHSUD that support parental and peer relationships and bridge health and social support paradigms, such as Multi-Dimensional Family Therapy (MDFT). Socially situated treatment programs such as MDFT, which include vocational, academic, trauma-informed responses to MHSUD have led to increased participant knowledge of substance-use and concurrent disorders, resulted in better coping capabilities among families and were associated with long-term maintenance of gains (Denomme & Benhanoh, 2017; Filges et al., 2018; Liddle et al., 2019). In another example of cross-sector approaches to youth MHSUD care, Thomas et al. (2020) found that School Based Health Centers—hubs for accessing physical and MHSUD supports within schools—"mitigate long term effects of poor health on children and adolescents" (p. 2) including mental health and substance use/abuse needs. The ability to access a primary care practitioner within their school community for triaging and referral to specialized treatments was shown to be vital, both as an access point for youth and also as a mechanism for school staff to work in close contact with health-care experts to support mental wellness for students (Szumilas et al., 2010). School Based Health Centers highlight the need for cross-sector responses to complex policy issues such as mental wellness and substance use. Furthermore, there is significant research lauding the success of implementing psychological supports such as Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT) in the school environment, led by medical professionals (Connors et al., 2021). In Manitoba, school-based therapeutic offerings fall on regional actors (such as school divisions) to build relationships with therapy providers and fund health-based offerings in schools. For example, River East Transcona School Division has recently started a pilot program by

partnering with Knowles Center to offer trauma therapy to youth with MHSUD in high schools, as a response to a lack of availability of care in the health system (River East Transcona School Division, 2022). In Manitoba, many high schools have Addictions Foundation of Manitoba (MB/AFM) counsellors working in schools on both preventative and reactive supports for youth, but MB/AFM consellors are not primary care pracitioners who are able to respond to substance use and mental health concerns alike.

Furthermore, there is much research calling for effective integration of Western health paradigms with Indigenous knowledge and culture (Maar et al., 2009; McIntyre et al., 2017; Schmidt, 2009), particularly related to community-based, culturally reflective service provision. Maar et al. (2009) described a small-scale but highly successful integration and implementation of a community-based mental health team approach that intertwines Indigenous world views/perspectives with Western psychology and social work. Their successful study involved creating a small, community based, multi-disciplinary, multi-cultural team that was both physically and culturally accessible and where integrated social, cultural, spiritual, health, and vocational outcomes were addressed. Morsette et al. (2009) supported community-based supports for youth with co-occurring disorders by setting up an access point within a First Nations community and offered an adapted CBT program, which incorporated and celebrated Indigenous perspectives and worldviews offered within First Nations communities. The Assembly of First Nations' (AFN's) 2017 *First Nations Health Transformation Agenda* examines varying governance models of health provision for Indigenous peoples across the country (discussed further below) but one of the basic tenets advocated is for the creation of health (and social) systems that are culturally aware and responsive, and in which all Indigenous people feel a sense of belonging and safety. There is ample evidence for, and exemplars of,

cross-sector and restorative approaches to youth MHSUD in Canada, which consider socio-cultural positioning, trauma, and developmentally appropriate care. Given short and long term effects of MHSUD on children and families, it is important to begin to consider how our existing federal system can support these best practices.

In the contemporary context, we have seen historical zero-tolerance approaches to MHSUD take a post-hegemonic position as shifting ethical underpinnings of MHSUD policy are altered. The politicization of decriminalization efforts, research on (childhood) trauma and MHSUD, the understanding of MHSUD as a mental health condition rather than an indication of failing character, the publicization of barriers to care, and the inclusion of primary prevention programming in school-based curriculum have resulted in care-based approaches to MHSUD. Given shifts in public perception of, and responses to MHSUD, investigation into how siloed policy sectors with their own intrinsic values and beliefs is important, insofar as it may illuminate opportunities for growth and alignment.

The Policy Context for Coordination: Provincial MHSUD Policy Landscape and Implications for Schools

This project is primarily aimed at uncovering opportunities for policy coordination in the Manitoban context. However, as laid out above, the numerous stakeholders invested in MHSUD supports for youth at multiple levels exist in all provinces in Canada's decentralized governance system. Provincially, ministries of education, health, justice and social services have formal legislation, policies, and guidelines to direct jurisdiction-based responses in the public sphere. Therefore, by virtue of Canada's decentralized federalism, the policy contexts of each province will be unique to the policy decisions in that area. Thus, in order to investigate the specific

configurations of and opportunities for policy coordination in Manitoba, this study sets out to compare the Manitoban MHSUD policy landscape (and implications for schools) with that of British Columbia. British Columbia was chosen as a comparator for a number of reasons.

First, in completing a scan of other Canadian provinces, there are a few which have launched progressive, decriminalized models of substance use response focusing on healing and supports rather than disciplinary responses. While Ontario has made some strong policy shifts in the last five years towards decriminalization (Pagliaro, 2021), British Columbia (and more specifically, Vancouver) has been by far the most progressive jurisdiction in terms of decriminalization efforts in Canada (Bains, 2023). Most recently, in June of 2022, the federal government announced an exemption in British Columbia for federal prosecution related to drug possession (Ghoussoub, 2022). This was in response to pressure from provincial policymakers who were vested in seeing health and social-based responses to drug use as a means to combat a continuing overdose crisis. British Columbia is the only provincial jurisdiction to have such an exemption.

Second, British Columbia was the first Canadian province to create a Ministry of Mental Health and Addictions (BC/MMHA), in 2017. Manitoba followed in 2021[6] with their own Ministry of Mental Health and Community Wellness (MB/MMHCW)[7]. Therefore, it may be that

[6] Following their win in the provincial election in fall of 2023, the newly formed NDP government in Manitoba has renamed this ministry as Ministry of Housing, Addictions and Homelessness. Given the timing of this change, and the fact that the previous ministry of Mental Health and Community Wellness published significant policy documentation related to MHSUD, I will use the acronym of MMHCW throughout this policy study. Additionally, I note that the alignment of addictions with homelessness rather than with mental health in this new model may further distance discussions of cross-sector work with MHSUD from schools with a health and social focus. Further research to investigate how this repositioning might impact supports for MHSUD alignment in schools will be important.

[7] It should be noted that other provinces also followed BC's lead with designated ministers or ministries devoted to mental health and substance use. However, in other provinces, these ministries appear to be less central than those in Manitoba and British Columbia. For example, both Alberta and Ontario have Associate Ministers for mental health initiatives, and neither of these jurisdictions have up to date strategies to support the ministries.

BC's lengthier experience implementing such a Ministry may provide some lived experience with regards to policy coordination for the Manitoban context.

Third, both Manitoba and British Columbia have recent, up-to-date, and currently implemented MHSUD strategy documents that guide practice around the area of youth MHSUD. BC's document titled, *A Pathway to Hope: A Roadmap for Making Mental Health and Addictions Care Better for People in British Columbia* was published in 2019. Manitoba's (not dis-similarly titled), *A Pathway to Mental Health and Community Wellness: A Roadmap for Manitoba* followed in 2022. British Columbia has been a national trailblazer in terms of decriminalisation, bureaucratic structures to support MHSUD initiatives, and provincial strategies that support youth. Given this context, this dissertation aims to consider the policy landscape of Manitoba in comparison to British Columbia's as a means to look for commonalities and investigate alternatives with regards to cross-sector policy coordination. Finally, BC seems to have a more established pattern of cross-sector approaches to MHSUD responses, which may provide some models for policy coordination.

Manitoba's *A Pathway to Mental Health and Community* (2022) document was developed out of a Manitoba Health commissioned report, which found that multiple siloed programs often hindered coordination between sectors and/or effective triage of patients requiring care (Virgo Planning, 2018). However, critics note that while the Virgo Report makes broad recommendations about cross-sector and policy coordination work, there are few references of how such broad goals are to be achieved (Froese, 2022). Thus, it appears that at this point in Manitoba, there is a push for coordination within the health sector but it is unclear to what extent there is an emphasis on service coordination, policy coordination or policy integration between sectors in a way that would support the education system. Alternatively,

British Columbia's *A Pathway to Hope* document was born out of previous cross-sector work on MHSUD. In particular, a 2010 multi-sector partnership initiative between the Ministries of Health and Children and Family Development had already framed MHSUD as a social and health issue. Furthermore, a 2015 Family Mental Health and Substance Use Task Force document (Select Standing Committee on Children and Youth, 2015) composed of multi-sector task force with stakeholders from Ministries of CFD and Health, along with the Advocate's office. While the education sector does seem to be missing from many of these initiatives, there is nonetheless more indication of cross-sector policy work to support cross-sectorial approaches in British Columbia.

Context for MHSUD Policy: Manitoba and British Columbia

In this section, I explore policy sectors and levels of governance that influence responses to youth MHSUD in Manitoba and British Columbia. Despite multilevel efforts to improve outcomes for children, a recent Manitoban report finds that, "Children and youth with complex needs face multiple, interconnected challenges which require formal collaboration among departments/ agencies, including but not limited to, child welfare, schools… the youth justice system, emergency departments… and mental health/addiction crisis and treatment services" (Virgo Planning, 2018, p. 40). In British Columbia, there is increased concern for at-risk youth in a province that saw 24 opioid overdose deaths for youth aged 10-18 in the year 2017 alone (British Columbia Representative for Children and Youth, 2017). That is, there is considerable work to do in both jurisdictions to ensure that ministerial policies and procedures result in cross-sector service provision that actually meet the needs of youth. In general, there are concerns that provinces lack governance mechanisms to monitor progress on policy implementation related the

extremely decentralized and multi-faceted arena of MHJSUD care (Witkorowicz, 2019). In most Canadian jurisdictions[8] there are both no provincial descriptions of mental health and substance use treatment services and no formal synthesis of relevant research literature to guide evolution and evaluation of MHSUD systems (Rush & Saini, 2016). Furthermore, provinces lack coordinated access to centralized and consistent supports because of the sheer number of federal, provincial, and regional actors involved. Mental health and substance use supports in particular require clarity regarding "the number of access points, services offered at each access point, referral process and scope of intake" (Rush & Saini, 2016, p. 3).

As is the case with other provinces in Canada's federalist system, Manitoba's and British Columbia's ministries of education, health, social services, and (the newly developed) ministries of mental health and addiction have significant power in legislating the ways in which regional actors and service providers respond to youth MHSUDs. As such, investigating the policy directives that guide service providers and local actors who are working with youth with MHSUDs is key, especially to investigate shared goals and visions in supporting coordination of policy sectors. Furthermore, as discussed above, there have recently been federal shifts in drug policy. These shifts emphasize restorative, harm-reduction, and decriminalized approaches to MHSUD issues. Evidence of these shifts include recent commitments to advance decriminalization efforts nationally, and to divert hundreds of millions of dollars towards combatting stigma, and to implementing "a full range of evidence-based treatments" for MHSUD (Liberal Party of Canada, 2022). This has prompted—in keeping with White's (2014) claim that federal resources are parachuted into existing policy frameworks—additional

[8] Rush and Saini (2016) are writing based on the Ontario context, but their insights into fragmentation are echoed by Virgo Planning's (2018) document outlining barriers to care in Manitoba, so I share their insights from a provincial level.

programs into an already complex policy and provincial service landscape. Below, I examine the federal injection of MHSUD policy responses at provincial levels and provincial ministry policy responses to MHSUD.

Federal policy involvement in provincial jurisdictions related to MHSUD. Drug policy has become an electoral issue in recent years, which has prompted increased involvement by the federal government in the provincial MHSUD landscape (Ziegler et al., 2019). While in general, this has taken the form of spoken commitments and provincial funding, it has also added a layer of policy and a layer of service provision to cluttered landscapes in the provincial arenas. *Canada's Drugs and Substances Strategy* (Government of Canada, 2018) is co-implemented by three federal ministries: Health Canada (HC), The Public Health Agency of Canada (PHAC), and Public Safety Canada (PSC). The Department of Justice also has peripheral involvement with substance use issues related to decisions to decriminalize certain aspects of drug policy. It is noteworthy that while HC, PHAC and PSC co-legislate drug policies and strategies nationally, their roles within this structure are unique. PHAC legislates and directs almost no policy related to MHSUD, aside from co-implementing the framework for *Canada's Drugs and Substances Strategy (2018)*. HC's involvement includes public awareness campaigns and public consultation. For example, in 2018, they produced a document titled, *Public Consultation on Strengthening Canada's Approach to Substance Use Issues* (HC, 2018), provided grants and other funding to provincial and regional substance use and addictions programs, and provided guidance/ recommendations with regards to MHSUD in alignment with other national and pan-national bodies such as Canadian Center on Substance Use and Addiction. That is, HC's structures related to MHSUD policy seem to align with the federalist model in which provinces

take the reigns on service provision and the federal government acts as a guiding, educative, and funding body.

Alternately, PSC—which governs such portfolios as disaster management and counter-terrorism—takes on significant pieces of MHSUD policy under it's portfolio of "Countering Crime" (PSC, 2022). Rather that providing guidance and funding for existing provincial MHSUD policies and service provision, PSC runs initiatives that are parachuted into existing policy sectors. For example, in Manitoba, PSC funds the Selkirk Team for At-Risk Youth (START) program, which is intended to support youth with drug and/or alcohol use, but also aggressive or violent behaviours, deviancy, and justice issues related to their mental health. The START program provides service coordination for inter-agency case planning in five discrete rural sites in Manitoba (PSC, 2022). In British Columbia, PSC runs 14 separate substance abuse prevention projects for youth. These programs are in many cases run and implemented by the Royal Canadian Mounted Police, adding another layer of policy actors to the provincial service provision picture.

Provincial Ministries of Education. Schools are in the unique situation when working with youth on a daily basis—schools do not implement waitlists, or complete criteria checks to determine the students they work with. According to Manitoba's Public Schools Act, schools are mandated to accommodate every student who walks through their doors. Therefore, school administrators and staff often end up being front-line workers on a multitude of health issues, including MHSUD. As a result, schools become sites where not only education policy, but also justice, health, and social services policies are enacted.

Manitoba. In terms of formal education policy in Manitoba, student substance use is dealt with in two discrete areas of legislation—a Ministerial Directive, which is an appendix to

the Public Schools Act, The Code of Conduct (Manitoba Education[9], 2017a), and the Health Curriculum (Manitoba Education, 2000). In the case of the Ministerial Directive, school divisions are legislated to develop Code of Conduct policies aligned with the directive (Manitoba Education, 2017a). My previous research (Colorado, 2000; Colorado & Janzen, 2000) documented the ways in which the Code of Conduct is framed as a disciplinary document presenting a duality of actions and consequences. In many cases, divisional education policies drawn from this provincial document seem to reflect a "tough on drugs" mentality that was common in the 1990s (Stimson & Fitch, 1999), including mandatory five-day suspensions for drug-related infractions, three strike policies, and potential expulsions (see Portage La Prairie School Division, 2005; River East Transcona School Division, 2004).

However, it is noteworthy that at a regional level, school divisions employ social workers, psychologists, trauma therapists, Addictions Foundation of Manitoba counsellors, and other specialized staff tasked with supporting youth to access intensive social and medical supports. Some divisional drug and alcohol policies do not dictate minimum suspensions (for example, Louis Riel School Division, 2022) and others mandate MB/AFM counselling for all students with drug or alcohol infractions (for example, Portage LaPrairie School Division, 2018; River East Transcona School Division, 2018). Certainly, in the case of Hannah, we can see that solely disciplinary response and/or educative responses would not have sufficiently supported her social and medical needs. Thus, in her case, school staff were tasked with stepping out of the "education" jurisdiction and finding ways to make sense of justice, social services, and health

[9] The Ministry of Education has changed names over the last ten years, including: Manitoba Education, Manitoba Education and Training, Manitoba Education and Advanced Learning and Manitoba Education and Early Childhood Learning. For reading ease, I use the term "Manitoba Education" throughout this dissertation, which is representative of all iterations of the ministry in the last ten years, as the mandate to direct K-12 education directives has remained consistent during this time. In the references I clarify which version of the office published particular documents.

policy to access care. That is, in absence of provincial direction, school personnel seek and forge regional partnerships (with MB/AFM, therapy providers, and teen clinics, for example) seeking treatment and care-based options for youth with MHSUD, rather than simply educative or disciplinary ones.

By comparison, the Manitoba Health Curriculum (Manitoba Education, 2000) is intended to provide education for students by presenting basic information on MHSUD and ensure that drug and alcohol preventative education is accessible to all students. As discussed above, there is significant data to suggest that school-based primary prevention programs have the potential to enact strong effect (Botvin & Griffin, 2006). However, in Canada this primary-prevention education modality lacks fidelity and consistency with implementation. In Manitoba, preventative drug and alcohol education is delivered through the health curriculum (which, at grades 9-12 is embedded in the physical education curriculum) (Manitoba Education, 2000). In other provinces, program reviews have implemented more robust, school-wide preventative programs (see Dell et al., 2013), rather than curriculum-based ones, and resting on curricula that are not more than 20 years out of date, as is Manitoba's.

Furthermore, while there are additional provincial education guidelines supporting mental wellbeing and well-becoming in Manitoba, it is noteworthy that substance use is not overtly mentioned in any of them. For example, Manitoba Education's (2018) document, *Planning for Safety and Belonging,* focuses on fostering mental wellness and paradigms of belonging. However, despite the documented concerns with youth MHSUD in Manitoba, there is not a single mention of substance use disorders in this document. Schools and other systems working to support the whole child are in a unique position to be able to offer "trauma-informed systems… characterized by principles of client choice, empowerment, collaboration, safety and

respect, resilience and the goal to minimize organizational re-traumatization" (Drabble & Jones, 2013, p. 22). However, by not overtly naming substance use issues in policy on mental health and wellbeing, there is a concern that school-based policy responses to MHSUD supports, as they currently exist in Manitoba, are not central to conversations about wellness, and therefore may contribute to a lack of supports to youth.

British Columbia. The British Columbia policy landscape in education with regards to youth MHSUD is similar to that of Manitoba's, though there are a few noteworthy differences. Provincially, the only policy reference to substance use is in the curriculum documents, specifically the K-12 Health Curriculum. Similar to Manitoba's context, there have been calls to bolster the preventative and educative drug programming in schools (Brown, 2017). Though regional school divisions have Code of Conducts that reference substance use, there is no provincial standard for inclusion of substance use as a disciplinary issue. As a result, there seems to be some significant differences with regards to how school divisions frame MHSUD in their own policy. While some school divisions discuss MHSUD solely in reference to disciplinary procedures (for example, Abbotsford School District, 2022), others spend only sentences discussing disciplinary impacts and instead have robust initiatives. An example of this is Vancouver School Board's (2022), *Substance Use Prevention Initiativ*e, a program that is intended to provide supports through regional service coordination models. Though Manitoba's largest school divisions have connections with MB/AFM services, Vancouver School Board has a district administrator devoted specifically to MHSUD resources, community partnerships, and coordination opportunities with regional health authorities, among other policy sectors (Vancouver School Board, 2022). That is, in absence of direct provincial coordination policy, there seems to be a more robust enactment of regional policy coordination mechanisms in

Vancouver between education and other sectors. This suggests that further inquiry into specific policy coordination approaches in that jurisdiction could be a helpful comparator for school division policies, for example, in Manitoba.

Provincial Ministries of Child and Family Services. Social services in ministries in both provinces direct responses to concerns regarding child welfare. The Ministry of Families (MB/MF) in Manitoba oversees provincial Child and Family Services (MB/CFS) legislation and policies. British Columbia's Ministry of Child and Family Development (BC/MCFD) directs legislation and policies that often come into play when schools are supporting youth, either because youth may already be in the care of child welfare, or because schools are mandated to report concerns of student wellbeing to child welfare authorities.

Manitoba. The MB/CFS Standards Manual (Manitoba Ministry of Families, 2021), a document outlining policies for social workers working alongside families and youth (including: youth interventions, family enhancement services, apprehensions, and ongoing care within MB/CFS), mentions youth substance use in only one section of the manual, "Working with Law Enforcement." This section of the Standards Manual discusses three other pieces of provincial legislation: *The Safer Communities and Neighbourhoods Act* (2020), *The Mental Health Act* (2003), and the *Youth Drug Stabilization Act* (2006). Each of these Acts legislate, among other things, the criteria that must be met in order for police to become involved either through arrest, or through emergent transport to hospital or a stabilization and detoxification center. This reliance on intertextuality—"specific and explicit cross referencing to other policy areas" (Rizvi & Lingard, 2009, p. 8)—is noteworthy. Intertextuality in this case seems to suggest that rather than building on opportunities for care, for example, via increased social supports or via increased coordination with the health care system, responses have been primarily linked with

justice-based responses. Ball (2006) noted that in cases where one discourse is employed over another, the choice to include a particular paradigm speaks to "what can be said, but also who can speak" (Ball, 2006, p. 48). In this case, the message seems to be one of control and punishment over care. The Standards Manual also provides direction to social workers on how to provide health supports to youth in need, and while this seems to include MHSUD supports, this is not formally stated in the manual. There is substantial other policy and legislation framework regarding the apprehension of youth, the contexts for family enhancement services, and other CFS protocols but there does not seem to be policy or pathways regarding social services supports to support youth needing MHSUD care. Nor is there, as Rush and Saini (2016) called for, a "roadmap" for caregivers or schools to follow to access social or medical supports.

British Columbia. Instead of relying on intertextuality to respond to MHSUD, as Manitoba does, the BC Ministry of Children and Family Development's (BC/MCFD), *Child and Youth Mental Health Services* (2022) document outlines access points, service providers, and types of social, psychiatric, psychological, and substance use supports available to all youth through BC/MCFD. That is, the scope of BC/MCFD in legislation in BC seems to be broader than that of Manitoba's, insofar as it provides treatment options internally, whereas in Manitoba CFS all MHSUD concerns are transferred over to the health sector. In contrary to Manitoba, which maintains legislation to hold youth involuntarily for substance use treatment, British Columbia has recently scrapped its similar legislation which had BC/MCFD work with law enforcement to forcibly treat youth with MHSUD following a court order (Bains, 2022).

Provincial Ministries of Health. It is noteworthy that throughout Canada, the move to have provinces establish regional Health Authorities was done in part to enhance service coordination possibilities regionally. However, the move to Health Authorities was also done

without any national or pan-national policy shifts to align potential coordination (Witkorowicz, 2010). While community-based services (for example, counseling, drug therapy, and social housing) can be more effective and cost-efficient than hospital-based care, they are also at capacity with long wait lists nationally (Wietkorowicz, 2019). Rush and Saini (2016) suggested that at the provincial level, there is a lack of synthesis of relevant research regarding supports for youth with MHSUD, transparency regarding available services to youth, and access points to available services. This fractured information base and access base, the authors have argued, limits the evolution and evaluation of coordinated models of care (Rush & Saini, 2016). In particular, when schools are needing to support youth with MHSUD, the lack of clarity from policy sector to policy sector limits effective coordination to support youth. In most Canadian provinces, even where wait list standards are mandated, it is not uncommon for youth seeking social supports and inpatient MHSUD services to be turned away (Palad & Snyder, 2019).

Similarly, the de-institutionalization of mental health care has resulted in integrated service networks and shared teams that are developed regionally but lack consistency (Witkorowicz, 2019). Although physicians are usually the first point of contact for families looking for support, their care is not well-integrated with community-based social and healthcare services (Maar et al., 2009). Resultantly, transitions between specialty, acute, and community-based care are not well-managed making the system difficult for patients with complex mental health and substance use needs to navigate (Witkorowicz, 2019). Social services and education sectors increasingly take on roles to fill gaps in the fragmented system. For example, school divisions employ psychologists, social workers, occupational therapists, trauma therapists, youth care workers, and addictions counsellors to ensure there are bridges to the medical system and to ensure that students receive care (Manitoba Education, 2022). The result is that the number of

regional actors employed by health authorities, social services, private organizations is significant, and they are not relegated to a single policy sector. Furthermore, given that individual school divisions direct clinical responses, a consequence may be inconsistent access to supports across different divisions.

Manitoba Health. Manitoba Health frames substance use as an issue of "health and wellbeing" (Province of Manitoba, 2021). A 2016 position paper written by the Chief Provincial Public Health Officer (Government of Manitoba, 2016) indicates that provincially, there is a commitment to "supporting people's efforts to minimize negative health and social outcomes" (p. 1) through harm-reduction approaches. Following concern over comprehensive approaches to MHSUD, including significant media content languishing the criminalization of mental health concerns (Karlenzig, 2021), the Ministry of Health commissioned a private report, *Improving Access and Coordination of Mental Health and Addiction Services: A Provincial Strategy for all Manitobans* (Virgo Planning, 2018). This report makes a series of recommendations regarding service coordination, including building relationships between sectors to avoid duplication; considering the importance of community service hubs for MHSUD; building MHSUD services into the community; and collaborating with primary care, MB/CFS, Justice, and school-based services. In the report, it is noted that, "sectors other than health are also providing significant mental health services for adults, as well as for children and youth, in particular, services through the Department of Families, Education and Training, and Justice" (Virgo Planning, 2018, p. 56). The document also noted that, "The Healthy Child Manitoba Office (HCMO) was intentionally constructed as a multi-sectoral collaborative partnership across the Government of Manitoba and was charged to create and implement a long-term, cross-departmental strategy for supporting Manitoba's children, youth and families" (p. 57). However, the dissolution of the HCMO in 2020

removed cross-sectoral oversight for social, health, and educational needs of youth as overseen by the National Children's Agenda, which was "a federal, provincial and territorial agreement initially designed to develop a comprehensive strategy for improving the health and wellbeing of children as a follow-up to a broad consultation conducted with the Canadian public" (Auclair, 2018, p. 4). That demonstrates a shortage of provincial-level service partnerships and coordination in Manitoba, and in fact a recent dismantling of previously existing coordination mechanisms like the HCMO.

The lack of shared vision—and fragmented policies in other sectors, which did not share health's service delivery framework—has been an over-arching barrier for MHSUD care in Manitoba. Currently, in Winnipeg, youth addictions supports are accessible in a variety of ways. School administrators, medical doctors, social workers, and youth correction officers are all able to refer youth to both public and private social and medical supports for youth with substance use concerns. For example, school staff in Manitoba are able to conduct school-based referrals for students to Addictions Foundation of Manitoba (MB/AFM) counsellors who have been sub-contracted by school divisions. Furthermore, youth, parents, social workers, and corrections workers can refer youth to the multiple separate regional access points funded by the WRHA for substance use support, including MB/AFM, Klinic, Native Addictions Council of Manitoba, MacDonald Youth Services, Manitoba Adolescent Treatment Center (MATC), Marymound, Youth Addictions Stabilization Unit, Resource Assistance for Youth, and Teen Talk (MB/MMHHLS, 2021). Parents, youth, and caregivers can also access supports by visiting a family doctor, or by accessing an emergency room or urgent care. Beyond these public service providers, there are multiple private service providers. As noted in *Improving Access and Coordination of Mental Health and Addiction Services: A Provincial Strategy for all Manitobans*

(Virgo Planning, 2018), this plethora of access points and services—many of which are fully booked, have wait lists, and have different entrance requirements and different eligibility criteria. This service landscape can be incredibly difficult for youth and families to navigate.

British Columbia. BC's Ministry of Mental Health and Addictions was formed in 2017, five years before Manitoba's Ministry of Mental Health and Community Wellness. BC's document, *Healthy Minds, Healthy People: A 10 Year Plan to Address Mental Health and Substance Use in British Columbia* was released in 2010, followed by the Ministry of Mental Health and Addictions' (2020) document titled, *A Pathway to Hope: A Roadmap for Making Mental Health and Addictions Care Better for People in British Columbia*. A review of the 2020 document indicates that formal cross-sector planning with integrated planning and policy models has been developed in BC. Therefore, a comparison of this document with the Manitoban document is useful in attempting to identify barriers to and opportunities for coordination in the Manitoban context.

British Columbia, like Manitoba, has a plethora of service providers dedicated to supporting MHSUD through BC Health. Like Manitoba, a referral page to service providers directs users to multiple entrance points, triage systems, and ways to access care. However, there are also attempts to support service coordination models. For example, a 24- hour Alcohol and Drug Information and Referral service (BC Health Link, 2022) allows users to receive support in navigating the policy landscape, aside from visiting a general practitioner. Alternately, though BC has established public physician guidelines that direct physicians and allow the public to have transparent access to treatment options, the only guidelines published for MHSUD include guidelines for opioid withdrawal and administration of opioids (BC Guidelines, 2022). That is,

there does not seem to be published guidelines for youth, parents, or physicians on supporting youth with MHSUD in either of those provinces.

Conclusions

This chapter has provided a comprehensive literature review and, thus, sets the stage for exploring Manitoba's policy context related to youth MHSUD. First, I introduced the concept of policy coordination as a goal to support integrated treatment models to best support youth and reduce barriers to care. In this section, I argued that while mutual adjustments, purposeful alliances, or imposed corporate structures may all be used to facilitate policy coordination, shared beliefs and corresponding shared interests are vital to achieving collaborative structures in any of these contexts. Furthermore, the section explored opportunities for lower-level service coordination and higher-level policy integration, and outlined how all levels of coordination are best supported through hierarchical structures and the identification of first-order principles. Finally, the section outlined the ways in which political, economic, and ideational changes in society mark points of bifurcation that might spur on policy change and opportunities for increased coordination.

Next, this chapter dug into Canada's federalist system which is made up of local, provincial, federal, para-national, and non-governmental stakeholders, resulting in a tendency towards siloed decision-making, and a paucity of top-down mandates. As a result of the fragmented arena of decision-making, much of the existing policy and service coordination is, thus, subjugated to regional and local levels, supported by a rise of non-governmental actors. Furthermore, the section explored how despite languishing social, health, and educational outcomes for Indigenous youth, that Indigenous governance in Canada's federalist system is

further fragmented by being intertwined with provincial mandates and federal control of Indigenous governance through projectified policy mechanisms such as Jordan's Principle.

I then reviewed how historical zero-tolerance responses to MHSUD in schools have been met with a shifting ethical landscape of MHSUD, including understandings of substance use as a mental health condition, decriminalization and harm reduction efforts, and new understandings of the relationship between trauma and MHSUD. The section also explored increasing acknowledgement of the barriers to MHSUD care, including accessibility, stigma, competing triage mechanisms, and cultural barriers. In response to such barriers, the section explored research regarding community-based service provision, socially-situated treatment options, school-based health care centers and culturally reflective service provision, in order to overcome these persistent barriers.

Finally, I focused more specifically on the specific provincial policy landscapes of Manitoba and British Columbia, both of which have announced cross-sector ministries intended to better legislate MHSUD responses. British Columbia has been a trailblazer of sorts in terms of decriminalization and legislation to provide supports to MHSUD and seems to have some higher-level cross-sector coordination at the provincial level—for example, having Child and Family Development take on some parts of child and youth mental health services—while Manitoba appears to have more coordination taking root at local and regional levels. Furthermore, both provinces are settled within a multi-level system in which Public Safety Canada and Health Canada still maintain tentacles of control via stand-alone programs.

This literature review, thus, sets the stage for an inquiry into opportunities for increased policy coordination in the Manitoban jurisdiction. Policy coordination is a goal which brings about improved service provision in dynamic and complicated policy landscapes such as in

MHSUD. When we consider the historical models of blame related to substance use against emerging models of care, it is also important to consider which social norms are inherent in the policies that are enacted on and with youth. Thus, knowledge of the constellation of actors is important alongside both the value positions supported by those actors and the types of coordination and intertextuality that exist in the policy responses, in order to investigate how we might better support coordination between all sectors.

In the next chapter, I present a conceptual framework to dig into both the policy actors in the policy subsystem of MHSUD, but also the beliefs that are inherent in policy interests and policy actions. A conceptual framework is necessary in order to assess if policy reform in such a fragmented federal arena of decision-making as in MHSUD has kept up with the research base related to MHSUD treatment modalities supporting opportunities for cross-sector coordination.

Chapter 3: Conceptual and Analytical Frameworks

This dissertation is rooted in understandings of Multi-Level Governance (MLG) with use of the Advocacy Coalition Framework (ACF) as conceptual and analytic frameworks. Given the multi-level and multi-actor reality of Canadian federalism, MLG is useful as a conceptual approach to explicate policy contexts at different levels of governance (vertical coordination) and between sectors (horizontal coordination). When considering the multiple stakeholders influencing cross-sector issues such as MHSUD, understandings of MLG can be utilized to elucidate the multi-level policy actors, their relationships, and the power-dynamics at play within competing vertical and horizontal frameworks. Within a MLG context, ACF can be used to analyze in detail the policy subsystems—that is, the multi-level and multi-sector actors who share interests and ideologies and drive forward value positions. Examination of value positions and dominant coalitions can be used to identify if the beliefs inherent in policy decisions reflect current research and shared beliefs and intents for youth with MHSUD responses.

In this chapter, I first provide an overview of Multi-Level Governance, then move on to unpacking the basic tenets and potential use of ACF as an analytical framework to this policy context. Following this, I present literature advocating for the use of MLG and ACF in tandem and discuss their co-applicability to the policy issue of students with MHSUD in the context of Canadian federalism.

Multi-Level Governance (MLG) as a Conceptual Approach

Multi-Level Governance (MLG) is useful as a conceptual approach, by considering it a lens through which to unpack Canadian federalism, which is decentralized in nature and characterized by vertical and horizontal relationships of stakeholders. MLG emerged from public

administration literature attempting to describe complex political networks, which contain multiple stakeholders and competing interests. Recently, MLG has been utilized to investigate, explain, and analyze networks of decision making, in specific policy sectors, including education, environmental policy, and international relations policies (see Anderson et al., 2017; Stephenson, 2013; Tamtik & Colorado, 2022; Tamtik & O'Brien-Klewchuk, 2020; Wyatt & Nelson, 2016).

Multi-level governance (MLG) as a framework was developed to understand how governance and decision-making are distributed across various levels of government and non-governmental actors. MLG emphasizes the importance of recognizing the complexity of governance in modern, interconnected societies. It argues for several key principles and perspectives, including: (a) acknowledgement of complexity of government systems including governmental and non-governmental actors; (b) awareness of the presence of both vertical and horizontal power-relationships between governments and policy sectors; (c) consideration of the diversity in stakeholder interest and purpose; (d) accountability structures marked by collaboration and interdependency and built into increased democratization of accountability processes; and (e) the potential for ongoing fluidity and policy change over time (Bakvis, 2013; Hooghe & Marks, 2001; Marks, 1993; Townsend, 2013).

The broad consideration of MLG across multiple domains reflects Conteh's (2013) argument that, "public policies are increasingly being implemented in concert with organized non-state actors in… inter-organizational, collaborative or partnership arrangements" (p. 18). In the contemporary world, decision-making processes focus on governance structures that utilize "networks, bargaining and interaction, rather than hierarchies" (Conteh, 2013, p. 31). Thus, MLG can be helpful to make sense of contemporary political systems, such as Canada's

federalist system, where the state remains the primary stakeholder but there are "continuous negotiation among nested governments at several territorial tiers…" to work alongside non-state actors in "…functionally specific policy regimes with overlapping membership" (Hooghe & Marks, 2003, p. 234). In the context of investigating policy responses to youth with MHSUD, MLG can be used conceptually as an umbrella term to identify the types of stakeholders involved in policymaking, map out the specific actors contributing to the policymaking process, outline the relationships between horizontal and vertical actors, and identify actors who may be under-represented in policy making. That is, MLG is not taken up as a theoretical framework on its own, but rather as an important heuristic that supports other conceptual frameworks. Thus, an overview of MLG mechanisms in the Canadian federalist context is useful to frame some of the dynamics in Canada's legislative and policy-making structure.

MLG identifies two distinct types of intertwined governance models: Type I and Type II. Type I refers to vertical relationships, based in federalism and embodying a discrete hierarchy in which there is a "general normative framework for the assignment of functions to different levels of government" (Hooghe & Marks, 2003, p. 236). In Canada, for example, Type I governance is seen in the hierarchical power relationships between international, federal, provincial, and municipal levels of government, which are nested in each other. Type II governance involves horizontal relationships with intersecting, rather than nested memberships, which are generally made up of task-specific jurisdictions. An investigation of the actors and relationships in both Type I and Type II governance, legislation, and policymaking is necessary to understand the arena of decision-making in Canadian federalism.

Application of MLG in Examining Policy Systems

As a conceptual approach, MLG can be used to explicate complex dynamics of governance and to investigate power, purpose, tensions, stability, and instability in such complex policy networks. That is, MLG can be employed diagnostically to investigate policy systems but cannot be employed constructively to actively build coordination between stakeholders. Efficiency in governance is a primary challenge in a MLG context, insofar as governing becomes more difficult when dealing with multiple actors, agendas, and interactions (Hooghe & Marks, 2003). This is partially because "tensions exist… between the traditional nested hierarchies of national political-administrative systems, … multinational agreements [and] a diversity of non-state actors" (Moss & Newbig, 2010, p. 2). These tensions require continual rescaling and aligning between stakeholders to allow for efficiency within MLG systems. Given this backdrop, MLG holds strength in being applied analytically—to identify gaps in accountability and democracy, and also comparatively—to investigate one policy structure vis-a-vis another (Stephenson, 2013). That is, a strength of a MLG approach lies in its ability to bring forward the complexity of policy processes, though it does not necessarily provide a pathway to increased policy coordination (Tamtik & O'Brien Klewchuk, 2017).

Investigations into policy purpose. In a MLG system, initiatives and policy-actions in a given policy area may sometimes be implemented without shared purpose by virtue of the number of independent actors involved, which can result in fractured policy implementation. In this context, a strength of utilizing MLG as a conceptual approach is the ability to explore shared purpose and strategic directions within a policy context made up of a large number of stakeholders with both horizontal and vertical relationships. Tamtik (2017) noted that without a "unified purpose, the type of values and norms that get promoted are determined by the

dynamics of complex networks and changing spheres of authority" (p. 3). Analytic frameworks that examine the interplay between policy actors—for example, the Advocacy Coalition Framework (Sabatier & Jenkins-Smith, 1988)—can serve to support examinations of which values and beliefs are being enacted through governance actions. Policies themselves, in such a context, are understood to be not simply stand-alone static documents and texts. Insofar as policies are representative of the contexts which inform and influence policy, the actors and construction of the problem itself, and the context in which it is applied all carry weight in the ultimate formation of the policy (Bowe et al., 1992). MLG is a useful conceptual lens when examining a policy context to ensure that multi-level and cross-sector relationships are fully considered. In the case of policy enacted in the school system, "the micro-political processes of schools [are] the environment within which policies, most of which are formulated by the central state, are effectively 'produced' and given particular inflections" (Hatcher & Troyna, 2006, p. 156). Policies and policymaking in this context present an "analytical corrective to models of the policy process which accord pre-eminence to the role of the central state in the articulation between policy making and policy effects" (Hatcher & Troyna, 2006, p. 156). In this conceptualization, policy is not just something that is done to people, it is the product of a discrete influence base (the context of influence), a particular representation of the problem (the context of production), and unique interpretations of action in the real world (context of practice) (Bowe et al., 1992). From an ACF perspective, these contexts are driven by value-laden deep-core beliefs about policy issues (Weible, 2006). Insofar as policies naturally encompass an authoritative allocation of values (Rizvi & Lingard, 2010), when we examine policies and the stakeholders that influence them, we can glean some information about the policies themselves, but also the social actors involved and the values that are being upheld.

Considerations of primary power holder(s). Decentralization of decision-making has resulted in an increase in policy actors within and across jurisdictions. With increased complexity across levels and sectors of policymaking, the question of who holds power is a complex and changing one. Wood (2013) argued that in the traditionally hierarchical Canadian context, policy is enacted in a constitutionally established system in which governing actors defend their "turf" because when power is handed over in small doses, stakeholders are hesitant to relinquish it. As a result, systems can get stuck in path-dependence where power holders may stay stagnant, even in changing social contexts (Cairney, 2012). As discussed earlier, in a decentralized federalist system such as Canada's, provinces tend to be independent and exclusionary when dealing with their own population in the absence of federal directives (Haskel, 2013). For example, Vergari (2010) argued that even in cases when provincial education ministers have agreed to shared decision-making in order to implement policies pan-provincially, regional modifications are still made in accordance with local values and priorities.

As education is a provincially governed jurisdiction, a MLG approach could be particularly useful to map out how specific stakeholders influence policy related to substance use in schools. Investigations into who holds power can serve to illuminate which norms are being upheld, and conversely, which voices are a part of and not a part of the public dialogue informing governance structures (Papillon, 2012; Verdun & Wood, 2013). For example, Bakker and Cook (2011) argued that fragmented responses from multiple levels of government with regards to water governance has led to negative impacts on Canada's ability to manage water resources. Tamtik (2017) argued that with regards to international education, with the increase of policy actors, "traditional authority and governance boundaries related to internationalization are becoming fluid" (p. 1); and Colorado and Janzen (2020) explored the ways policies within

Manitoba Education (provincial Ministry) itself contradict each other as a result of speaking to different policy sectors on common issues. In short, there are accountability gaps resulting from decentralized governance that require investigation for discrete policy sectors (Millar, 2013).

Insights into instability and democratization of MLG systems. A shortcoming of MLG's approach is that inquiries into collaboration between state and non-state actors can only be considered a temporal assessment and can change over time. Any inquiry into actors and the relationships between those actors in a Canadian MLG system are jurisdictionally specific; primary power holders may not be the same from place to place (or province to province), so theories are not necessarily scalable. Conteh (2013) suggested that a MLG approach "does not necessarily presuppose the decline of the state, but rather presents an analytical framework for assessing the state's ability to adapt" (p. 29). Centralized governments are not well suited to accommodate diversity; large-scale decisions tend not to be able to be reflective of regional voices, but "multi-level governance allows decision makers to adjust the scale of governance to reflect heterogeneity" (Hooghe & Marks, 2003, p. 236). Because multi-level systems tend to "soften the shells of institutions and induce those in diverse institutional settings to connect with each other" (Hooghe & Marks, 2001, p. 149), there is potential for an increase in policy actors not previously part of the policy landscape in vertical or bureaucratic models of decision making.

A further limitation of MLG as a conceptual approach is that with increased informality in decision-making "it is challenging to determine how decisions were reached, what was the specific mechanism and which stakeholder group had most influence" (Tamtik, 2017, p. 12). In this way, MLG can contribute to the democratization of governance as it allows citizens to become value creators in the contemporary political context (Conteh, 2013) but as a result creates a fluidity in policy decisions. This democratization also produces concern of a danger of

accountability deficits (Harlow & Rawlings, 2007; Olsson, 2003) in self-organizing and self-regulating networks which may lead to increased bias and lobbying in governance over time (Stephenson, 2013). Thus, inquiries into MLG systems are temporal and volatile and may be able to map out changes in actors and norms in a policy area.

Advocacy Coalition Framework as Analytical Framework

Developed by Sabatier and Jenkins-Smith (1988), the Advocacy Coalition Framework (ACF) is framework that can be utilized "to understand belief and policy change when there is goal disagreement and technical disputes involving multiple actors from several levels of government, interest groups, research institutions and the media" (Weible & Sabatier, 2006, p. 123). The ACF is a framework in the field of policy studies that argues for a comprehensive understanding of the policy process, emphasizing the role of advocacy coalitions in shaping public policies. ACF provides insights into how policies are formulated, implemented, and changed over time. It specifically focuses on advocacy coalitions in shaping policies, particularly by forming policy subsystems and engaging in policy learning as key mechanisms for policy change. ACF allows for explication of ideological conditions and value positions within multi-level systems that inform policy change. An understanding of MLG landscapes and policy actors is useful background information from which to engage with the ACF. However, rather than simply identifying actors and the relationships between them, the ACF can be used to examine the underlying beliefs within policy subsystems. ACF has been used to explore multiple policy areas, including environmental science, domestic violence, and drug policy (Gover et al, 2003; Kubler, 2001). ACF holds that the most useful way to think about policy change or differences in policy from jurisdiction to jurisdiction, is through focus on policy subsystems. According to

Sabatier and Jenkins-Smith (1988), a policy subsystem consists of "actors from public and private organizations who are actively concerned with a policy problem" (p. 131)—administrative agencies, legislative branches, interest groups, journalists, policy analysts, and researchers. All enter the policy-making sphere in this framework and tend to be clustered around sets of shared values and beliefs. Policy actions from these stakeholders take the form of policies, legislation, guidelines, support documents, position papers, and media interviews.

In the context of ACF, policy construction and policy change take place within relatively stable environmental parameters, for example, an ongoing constitutional structure within a federalist system, relatively stable social structures, and continuing attributes of a problem area. Within these relatively stable parameters, ACF posits that coalitions tend to form within policy areas, based on belief systems (Weible & Sabatier, 2006). That is, collections of policy actors form coalitions based on similar ideological views in policy areas, and "each coalition adopts a strategy… involving the use of guidance instruments to attempt to alter the behaviour… of governmental institutions" (Jenkins-Smith & Sabatier, 1994, p. 182). At a simplified level, ACF can be understood as a tripartite belief system where: (1) policy actors form coalitions based on "deep core" beliefs—normative and ontological axioms that hold value judgements; (2) based on these deep core beliefs, coalitions form "policy cores"—beliefs concerning the underlying causes of a problem; and (3) based on these understandings of policy core, "secondary beliefs"—specific policy preferences—are formed (Auld & Morris, 2016). ACF "presumes that individuals are rationally motivated but are bounded by their imperfect cognitive ability… to simplify events and the world around them; ACF holds that individuals filter perceptions through their belief systems" (Weible & Sabatier, 2006, p. 127). As an analytical framework, then, ACF can be used to investigate policy actions over time to explore underlying value positions and either overt or

subtle policy core coalitions to consider which deep core beliefs may have monopolies in a particular policy context. Furthermore, given existing policy coalitions, ACF can be used to monitor shifts in policy actions in response to external perturbations to a policy subsystem. Policy coordination is often best enacted through policy learning and changing political or social factors within a policy system (Wallner, 2017). Thus, examining policy actions to identify core beliefs and shifts in values has the potential to map out opportunities for policy learning, policy change, and coordination.

In sum, the enactment of policy and the learning that takes place from existing policy is as much a part of a policy cycle as the intended outcomes of policy. Whereas MLG can be used to demonstrate policy actors in a given time, ACF can be used to map coalitions' developments over time. Bowe, Ball and Gold (1992) have argued that the contexts of influence, production, and practice are each part of the policy cycle. Thus, policy learning—shifts and learning that take place in the context of practice—can be investigated to determine whether individual policies and policies working together are in fact upholding the policy agendas and intended outcomes that were present when policies were initially developed. Similarly, at the core of ACF "is the assumption that policy making is driven by groups of actors who coalesce around shared beliefs and coordinate to promote policies that align with those beliefs before others do the same" (Koebele, 2019, p. 38). That is, policies themselves are representatives of temporally and geographically located values and beliefs. Thus, investigations of these polices to unearth belief systems and compare contexts of influence against contexts of production and practice, can be used to explicate policy landscapes for highly moralized issues such as MHSUD. Thus, within ACF, mapping stakeholder actions over time can be used to elucidate unspoken deep core beliefs and underlying coalitions.

ACF application to investigate policy systems. Jann and Wegrich (2007) noted that, "policy-making pre-supposes the recognition of a policy problem" (p. 46) and that all policy solutions frame a policy problem within a value-laden discourse. The utilization of ACF, thus, allows researchers to examine both the advocacies and policy agendas underpinning current policy landscapes. In this section I explore how ACF can be used analytically to explore value positions in policy subsystems.

Drawing attention to underlying discourses. Rizvi and Lingard (2009) argued that, "policies have discursive effects, often changing the language through which practitioners engage with policy in practice" (p. 7). Within ACF, organizations use knowledge and platforms to frame policy issues in ways that benefit or reflect underlying deep core beliefs about a policy problem. Often, this takes the form of three discrete steps (Auld & Morris, 2016): (1) a policymaking group establishes a logic of action, often based on crisis rhetoric rooted in deep core beliefs (for example: drug-involved youth are a danger to society and, thus, action must be taken); (2) policymakers employ a strategy of expertise, establishing advocates' credibility through reputation and credentials (for example, by forming a review or an expert task force to examine the extent of youth drug use in schools); and (3) policymakers restrict analytical focus to measurement of policy process to quantifiable outcomes and excludes broader information and intended consequences (for example, using low test scores as indicators of school-based success rather than broader social outcomes like poverty or access to mental health supports). In this way, the construction of particular policy problems and policy solutions within ACF can take the form of "selective exposure" in which there is an "important distinction between how conclusions are developed and how they are justified" (Auld & Morris, 2016, p. 214). This process of obfuscation contributes to a "policy monopoly" in which coalitions monopolize a

political understanding of a particular issue (Jann & Wegrich, 2016). For example, by framing MHSUD as a safety issue, rather than a medical or social issue, the response is likely to reflect discourses of control, rather than care. Further, if different coalitions have more power in different sector (for example, different deep core beliefs supporting health policy than, for example, education or social services policy), ACF structures may end up in fractured policy responses between sectors.

Mapping storylines of control and reform. Auld and Morris (2016) argued that there are two broad storylines used in policy texts within democratic governments: a story of decline, which provides impetus for reform; and a story of control, which inspires faith that issues can be fixed. In both contexts, policymakers create narratives that support arguments for change. In this context, "mapping beliefs and policies on the same canvas permits assessing the influence over time" (Jenkins-Smith & Sabatier, 1994, p. 180). That is, looking singularly at policies does not necessarily illuminate who is holding power and shifting policy narratives moving forward. ACF examinations of stakeholders' deep core beliefs alongside policy implementation can be used to determine whose purposes purported "reforms" might serve. In general, through an ACF context, policy learning and change will take place as competing coalitions work within relatively stable contexts to shift policy. In this context, changes to deep core beliefs and secondary beliefs are unlikely. However, external system events such as changes in socio-economic conditions, public opinion, and systemic governing coalitions may make larger scale change possible. Thus, external events—for example, in the case of MHSUD shifting public opinion, deeper understandings of mental health following COVID-19, the TRC's calls to action, and public outcries in response to the "opioid crisis"—have the ability to prompt policy learning and subsequent reforms.

Jann and Wegrich (2007) claimed that policies implemented within policy succession environments where new policies are developed "in a dense environment of already existing policies" (p. 45) often take on sluggish progress. In a policy context cluttered with policies and procedures, the result may be that while deep core beliefs or secondary beliefs evolve and additional policies are implemented, little real change is initiated. Change in which policy core or deep core beliefs of coalitions are moved "require rigorous organizational inquiry; continuous practice of examining assumptions, surfacing and challenging mental models and acting on what is learned" (Boyce, 2003, p. 128). Furthermore, Jenkins-Smith (1994) argued, "while policy-oriented learning is an important aspect of policy change and can alter secondary aspects of a coalition's belief system, changes in the policy core aspects of a governmental program are usually the result of perturbations in non-cognitive factors external to the subsystems" (p. 183). Thus, a strength of ACF may be to investigate stakeholder alliances and predict opportunities for changes in deep core beliefs in MLG systems.

Benefits of Utilizing MLG Approach and ACF in Tandem

Luke and Hogan (2006) argued that it is imperative to see the "normative nature of education policy" insofar as these normative beliefs effect "the broader social, cultural and economic domains" (p. 171). As discussed above, MLG and ACF both have applicability to investigations into normative discourses in policy and the kinds of policy actors and policy beliefs that are being supported within a landscape of multiple stakeholders. While MLG is useful as a conceptual approach to unpack the policy actors involved, their relationships, and who holds power, the ACF can be employed analytically to uncover the value-laden priorities being supported by existing policies and the coalitions that follow out of these values. A number

of researchers (Koebele, 2019; Marrot & Sager, 2018; Pratt, 2012; Princen, 2007) argued for the benefits of utilizing a MLG approach alongside the ACF as a "shared research platform" (Koebele, 2019, p. 36) to explore and analyze similar policy phenomena. In general, while both MLG and the ACF share an understanding that complex networks of stakeholders share knowledge and effect policy change, the ACF is unique insofar as it "rests on a set of normative ontological values" (Mavrot & Sager, 2018, p. 56). Pratt (2011) argued that the aspect of ACF, which maintains an "emphasis on subsystems and ideological foundations" differs from MLG approach's focus on "multiple interwoven levels of governance and [a] recognition that governance goes beyond the functions of organized political units" (p. 29). Thus, when investigating MLG structures, "it is more useful to look at shifts between the competing advocacy coalitions in a given issue area" (Princen, 2007, p. 13). Furthermore, while MLG can be used as a conceptual lens through which to examine policy and the policy-making context, it is important to note that ACF is a framework, which, distinct from theories and conceptual approaches, provides analytic guidance towards explanatory inquiry.

From the perspective of the ACF, and consistent with the literature on policy coordination (Wallner, 2017), policy change and policy coordination can occur through a number of mechanisms, which are not mutually exclusive. Policy change may occur when there is a significant external perturbation—such as a rapid rise in drug-related deaths and ensuing public outcry—that is then responded to by the dominant coalition. Policy change and coordination may be prompted when a new coalition, with its attendant beliefs, becomes dominant—for example through a change in government from a more conservative governing power to a more liberal one (or vice-versa). Policy change or coordination may also ensue through policy learning, for example, when a dominant coalition sufficiently changes its secondary beliefs to inform change

in policy responses (Hogl & Nordbeck, 2012; Jenkins & Sabatier-Smith, 1994). That is, current trends in MHSUD policy, including moves to non-punitive drug models, de-criminalization, and calls for restorative supports rather than zero-tolerance can serve to make previously dominant coalitions become unstable. Consideration of the level of government and the sector of policy-making in which policy change is occurring allows for an identification of advocacy coalitions which are influencing policy, and an inquiry into the levels and structures of governance in which these coalitions are operating. Insofar as Tamtik and O'Brien (2020) suggested that a "disconnect is often observed between the intended policy outcomes and practice" (p. 1), it is important to unpack current policies, deep-core beliefs, and advocacy coalitions to determine if they uphold public values and research-based recommendations and to see if deep core beliefs are consistent between policy jurisdictions and levels of governance. Understanding the policy actors at play and mapping out differences in the value positions in existing policies thus make MLG and the ACF useful models to predict change and opportunities for coordination in youth MHSUD policy.

Furthermore, in MLG contexts where both stakeholders and deep core beliefs are fractured at different levels of government, the ACF is a useful framework to uncover shared and conflicting goals, values/beliefs, and directives. Youth MHSUD is understood as a multi-sector issue (Das et al., 2016), however, different policy contexts may frame discussions of substance use in discourses of preventative care, social supports, health-care provision, or punitive responses. For example, Watson (2019) argued that public and biomedical health responses are intended to mitigate social and individual harms associated with stigma and drug use. Often this policy goal is not upheld by other policy contexts, —that is, justice policies may criminalize substance use and school-based policies may be rooted in zero-tolerance (McIntyre, 2019).

Consideration of the vertical and horizontal positioning of policy actors in a MLG system can thus be useful to unpack some of the influences affecting policy values in different policy actors.

Within a complex, multi-level policy subsystem with multifarious stakeholders, many tools and methodologies have been employed to unpack data. Stakeholder Analysis is one such tool, which can be useful in untangling both a multiplicity of multilevel policy actors and policy interests in beliefs in a complex system. Stakeholder Analysis is defined by "identifying opportunities and constraints for calculating the likelihood that a strategy, venue, or alternative will be successful in initiating or preventing belief and policy change" (Weible, 2006, p. 95). In the case of youth MHSUD policy in Manitoba, there has been little policy analysis outside the health care sector (Virgo Planning, 2018), despite a significant amount of multi-level stakeholder input in the forms of policy, guidelines, directives, youth advocacy, media reports, position papers, and non-governmental stakeholders. Given the significant amount of literature, policy development, and policy advocacy that has been put forward in this policy area, multi-sector, multi-level policy analysis to support an ACF investigation into the deep core beliefs inherent this policy sector and the advocacy coalitions controlling governance mandates is timely and important. In sum, MLG can be used to identify actors, relationships, and the contextual factors existing in the Canadian federalist system. ACF provides a framework to systematically compare the stakeholders within policy subsystems, the core beliefs and value positions inherent in policy actions, the coalitions based on value positions, and the opportunities for—and storylines of reform.

Conclusion

Insofar as understanding political systems is an important step in recommending alternatives (Weimer & Vining 2005), an "understanding of the political dynamics of the subsystem is essential" in order to develop a good understanding of the political context of the problem (Heinmillar, 2016, p. 23). Both MLG and the ACF have applicability to understanding policies related to youth MHSUD in schools. Given the moralistic nature of the policy issue of MHSUD, deep core beliefs and values underlying policy decisions play an important role in this policy area. An inquiry utilizing only MLG as a conceptual approach may be beneficial to map out the multilevel policy actors and the demonstrated links between them. However, it would not be able to explicate the deep core beliefs that fuel policy monopolies, to compare policy beliefs between regions/levels of governance, or to call out deep core beliefs, which may be operating in contradistinction to established norms and values in society. In sum, rather than using one or the other, utilizing the ACF analytically with MLG as a conceptual lens is useful to diagnose both relational interdependencies, and examine unspoken values being supported.

Chapter 4: Methodology

The methodology for this study is guided by the primary research question:

> How can policy coordination be utilized to improve multi-sector support for youth with MHSUDs in Manitoban schools?

and the following sub-questions:

1) What policy stakeholders and corresponding documents currently guide responses to youth MHSUD in general, and school-based responses in particular in both MB and BC contexts?
2) What are the interests, beliefs, policy actions, and coordination mechanisms that are implicit and explicit in these documents?
3) What are the documented impacts of the current policy landscape for youth in both jurisdictions?
4) How do the documented interests, beliefs, policy actions and coordination mechanisms compare between sectors, jurisdictions and levels of government?
5) What can we learn from provincial comparisons? What recommendations for policy coordination can be made to support MHSUD supports in Manitoba schools?

Using a qualitative research methodology employing a case-study approach with comparative analysis, this project explicates, analyzes, and critically evaluates MHSUD policy responses in Manitoba and compares it to B.C. context.

Methodology: Qualitative Case Study Approach

This study employs qualitative research methodology with comparative analysis. A qualitative methodology is used with the understanding that knowledge is socially constructed, and, thus, meanings must be investigated as being grounded in social beliefs that can change

depending on social interactions (Flick, 1999). Qualitative methodology involves an analysis of the world in its existing state and can serve to "provide rich descriptions of complex phenomena" (Sofair, 1999, p. 1101). Given this project's goal of reviewing an expansive amount of policy documentation, a qualitative methodology which seeks to describe, interpret, verify, and evaluate a data set which cannot be manipulated by the researcher (Peshkin, 1993), allows for an analysis which takes on a holistic treatment of a complex phenomena (Njie & Asimiran, 2014).

Within a qualitative methodology, a case study approach is defined as an investigation into a "contemporary phenomenon in depth and within its real life context, especially when the boundaries between phenomenon and context are not clearly evident" (Yin, 2009, p. 20). Case study research focuses on answering "how" or "why" questions, where targetted events are independent of the researcher's actions (Yin, 2009). Case studies contribute to existing knowledge by relying on multiple sources of evidence and by resting an inquiry on a determined theoretical predisposition. Furthermore, in terms of comparative analysis, a comparative case study is useful "to explain the similarities and dinsitnctions between observable phenomena between cases" (Blair-Walcott, 2023, p. 110). Comparisons between case studies in cross-border comparisons can explicate differences in social, ideological, economic, and political contexts regarding a common issue, which can then be utilized as explanatory power in research (Blair-Walcott, 2023),

In this dissertation, the case is defined as the discrete Manitoban provincial policy subsystems directing responses to youth MHSUD which co-exist in a larger federal system. The primary case, the Manitoban policy subsystem is compared with a secondary case, specifically, MHSUD in BC. Using an embedded comparative case design, this dissertation will investigate

policy documentation in the Manitoban and BC policy subsystems of student MHSUD[10]. This case study research design utilizes MLG as a conceptual approach and ACF as an analytical framework to inform and ground a Stakeholder Analysis. Stakeholder Analysis, in this thesis, is treated as a specific methodological approach, suggested by Weible (2013), that focues on explicating stakeholder beliefs, interests, policy actions, and coalitions. In alignment with ACF, Stakeholder Analysis helps to bring forward the beliefs, interests, and actions which are underlying in complex policy contexts. Weible (2013) argues that Stakeholder Analysis:

> focuses on mapping the activities of multiple stakeholders employing multiple strategies in multiple venues. This broad perspective is extremely important in…any other political system that is open to multiple participants, where authority is shared among actors and institutions, and where there are ample opportunities for losers of one policy battle to strike back against winners later in the policy process. (Weible, 2006, p. 96)

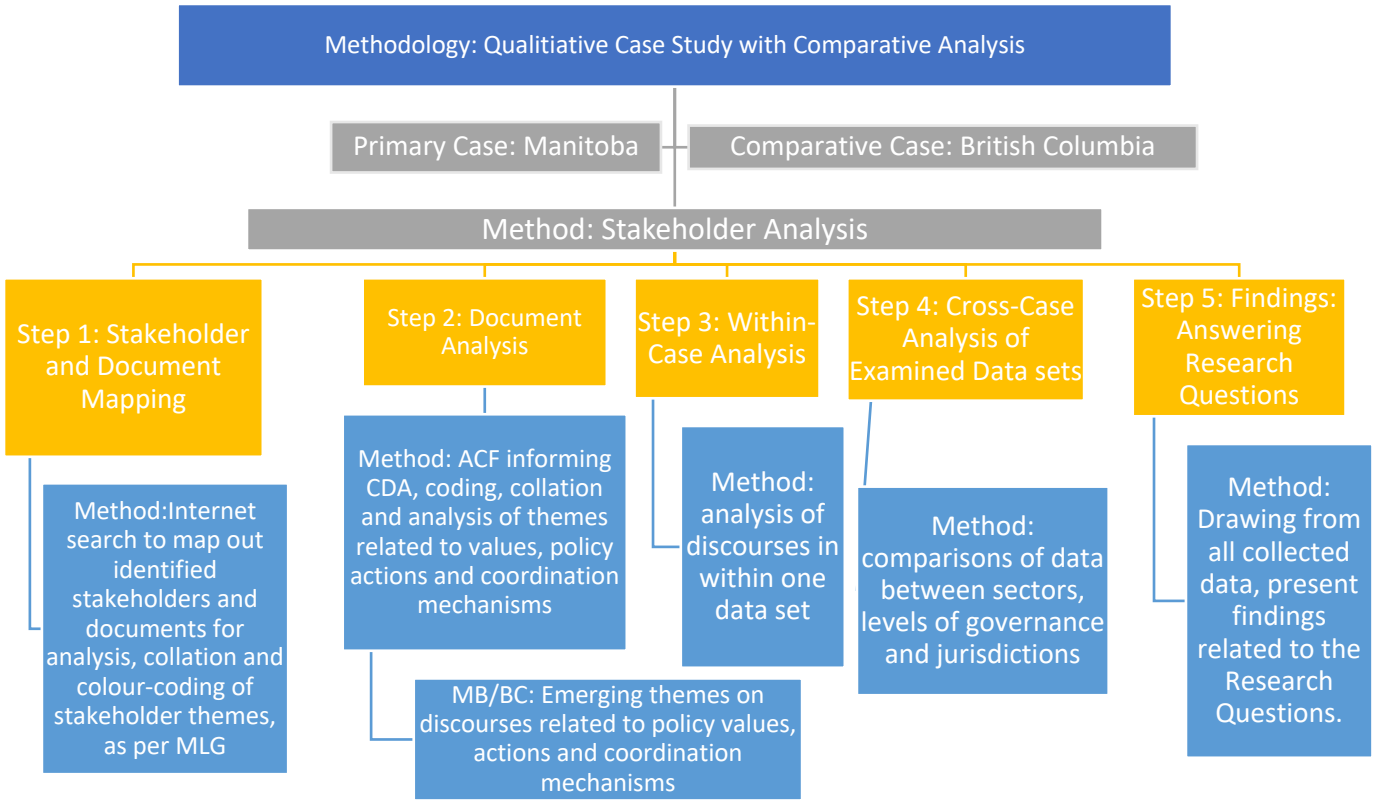
That is, this comparative case study of different policy subsystems used MLG as a conceptual approach in order to conduct Stakeholder Analysis of policy actors and actions, as per ACF to investigate the policy subsystem of MHSUD responses in schools.

Methods

The Stakeholder Analysis grounded in MLG as a conceptual approach and ACF as an analytical framework involved five steps of interconnected methods. Table 4.1 shows the methodological framework for the study and maps out the methods that were undertaken in service of the established research questions. Specific methods are explored below.

[10] Rationale for using BC as a comparator is explained in Chapter 2.

Table 4.1
Methodological Framework for the Study



As shown in Table 4.1, in order to take on this work, the following steps were undertaken:

1) Using MLG as a conceptual lens, the project mapped out the multi-level and multi-sector stakeholders and policy documents in the policy subsystem of youth MHSUD in MB and BC. This was done through internet search, organizing data by visual mapping and colourcoding various stakeholder groups.
2) Identified documents from each of these stakeholders informed a Stakeholder Analysis—using Critical Discourse Analysis with an ACF lens. This was done by reviewing each policy document and coding data to identify discourses of intent (drawn from collection and coding of signifiers demonstrating interests and beliefs inherent in the documents); discourses of

action (drawn from collection and coding of signifiers demonstrating resources and strategies deployed in service of policy interests); and discourses of coordination (drawn from collection and collation of signifiers demonstrating catalysts and barriers to coordination in the examined documents).

3) Discourses were analyzed within case groupings (by level of governance, by province, by jurisdiction, and by sector).
4) Cross-case analysis was used to compare discourses between levels of governance, jurisdictions, and sectors.
5) Findings were presented and recommendations with respect to the research questions were explored.

Below I elaborate on each of the steps, the specific methods and decisions that were made for data analysis.

Step One: Identification of Stakeholders and Document Mapping guided by MLG

I used MLG as a conceptual approach to conduct Stakeholder Analysis. A MLG approach was used to identify the multi-level policy actors and corresponding policy documents in the policy subsystems of MHSUD.

Identification of stakeholders. Given Canada's MLG policy context, mapping out the policy stakeholders in different sectors and levels of governance was a key starting point to understanding the values and relationships inherent in the MHSUD policy landscape. Drawing from Weible (2006), I identified the following stakeholders as part of a policy subsystem: (1) federal government officials; (2) state/provincial government officials; (3) regional/regional government officials; (4) interest groups, community organizations, and nongovernmental

organizations; (5) media outlets; (6) target groups, and (7) researchers. Researchers have been represented already in this project via the literature review (see Chapter 2) and thus will not be further investigated within the methods. Furthermore, Weible (2006) argued that stakeholders typically belong to a policy subsystem if they: (a) use policy core beliefs to structure advocacy coalitions; (b) utilize resources, including legal authority, public opinion, information, personnel, financial resources and leadership; (c) attempt to influence policy in venues; and (d) initiate policy belief change.

Given this criteria, the first step in this research was to to complete an environmental scan of the multi-level stakeholders in both Manitoba and British Columbia. Informed by MLG's cross-sector and cross-level premise, stakeholders were identified across different levels of governance and across several ministerial policy sectors. Identification of the positionality of stakeholders and the types of relationships that existed between those stakeholders were also examined. It is important to emphasize here that this Stakeholder Analysis sought to examine discourses in policies drawn from key stakeholders in the policy subsystem of youth MHSUD, and is not a scoping analysis of each and every policy document from each and every policy stakeholder. In general, given the project's aim to identify coordination opportunities in a MLG context, I focused on sectorial/ministerial responses at different levels of governance.

In determining stakeholders for inclusion, I identified multi-level policy actors who create policy documents with a mandate to direct responses or provide supports to youth MHSUD including federal governmental offices and ministries, national level Indigenous governance offices, provincial government offices and ministries, provincial level Indigenous governance offices, regional governance offices, multi-level NGOs, jurisdictional CBC news media, and provincial Advocate for Children and Youth/Representative for Children and Youth

reports which highlight data and experiences of youth. In general, given the project's aim to identify coordination opportunities in a MLG context, I focused on sectorial/ministerial responses at different levels of governance.

Throughout this thesis, I developed charts and tables to organize data. To increase reading ease, I colour-coded stakeholder groups as demonstrated in Table 4.2.

Table 4.2
Colour-Coding of Stakeholder Groups

Federal Stakeholders
Provincial Stakeholders
Regional Stakeholders
Non-Governmental Organizations
Media
Target Groups

Federal stakeholders. In order to map out federal stakeholders, I first completed a scan of websites of federal governmental ministries, pan-national governmental organizations, offices, initiatives, and departments that contributed to any federal, governmental legislation regarding responses to youth MHSUD. I then reviewed federal legislation, cross-sector initiatives, and funding arrangements to identify any additional federal governmental stakeholders who may have influence in the policy subsystem of youth MHSUD service governance. These additional stakeholders included governmental ministries, cross-sector partnerships, and federal offices who direct or respond to youth MHSUD and national Indigenous governance bodies. Though there are federal partnerships with non-governmental organizations (NGOs), particularly through funding agreements, these NGOs were not included as federal stakeholders and instead were reviewed as part of the stakeholder group of media and NGO stakeholders below. Furthermore, though Justice Canada is a key producer of policy responding to substance use related to criminality, justice-related stakeholders were not included in this study because this research is focused on supports for youth MHSUD and not on substance use as a criminal issue.

Provincial stakeholders. At the provincial level, I focused on provincial ministerial offices and provincial policymakers that direct responses to youth MHSUD. This included ministries of health, mental health, education, and child welfare in both Manitoba and British Columbia. I also reviewed legislated provincial partners to these ministerial bodies—primarily producers of reports and publications, and cross sector partnerships. Provincial level Indigenous governance bodies with policy influence on mental health provision and MHSUD were also included at this level of analysis.

***Regional stakeholders*.** Regional actors were determined to be sub-provincial actors with a regional (city-wide or division-wide) service mandate. Certainly, within regional governance areas there were also countless sites of service provision (for example, medical offices, therapy centers, rehabilitation centers, schools, Indigenous groups) that have policies and procedures related to MHSUD. It is not within the scope of this project to complete a policy review of all the service providers within this policy subsystem, but rather to analyze the broader policy landscape that service providers work within. Furthermore, when analyzing the identified documents, key service providers that influence and are influenced by the policy subsystem will naturally be highlighted via their positioning in federal, provincial, and regional documents.

Given the vast number of regional actors in the ministries of health[11], child welfare, and education in Manitoba and BC, a document analysis including each regional actor was not feasible for a study as broad as this. Instead, a representational sampling was drawn from regional bodies working under provincial mandates. As shown in Table 4.3, this data set included: (a) the largest school district/division in both Manitoba and BC—under the premise

[11] Though there are provincial ministries of Mental Wellness in Manitoba and British Columbia, at the regional level, mental health services are coordinated within the health care system so all regional stakeholders focused on mental health are examined within the health care system.

that larger institutions will have developed coordination paradigms out of necessity; (b) both provincial health authorities and the largest regional health care authority in each province—again with the assumption that larger organizations will have more opportunities for having developed exemplars for coordination; and (c) one Child and Family Services authority in each province (where there are regional offices). Given this inclusion criteria, in Manitoba the Winnipeg School Division (WSD), Shared Health (SH), Winnipeg Regional Health Authority (WRHA), and Southern Chiefs Organization Southeast Child and Family Services Authority (SCO/SECFA) were selected as stakeholders for analysis. SCO/SECFA was included for two main reasons: (1) it is one of the largest CFS authorities in Manitoba, and in keeping with inclusion criteria for education and health, I presumed that a larger organization would have developed more opportunities for coordination; and (2) as an Indigenous authority, I postulated that as a representative stakeholder it would have exemplars of Indigenous, culturally responsive coordination partnerships.

In British Columbia, The Vancouver School Board (VSB), First Nations Health Authority (FNHA), BC Provincial Health Authority (BCPHA) and Vancouver Coastal Health (VCH) were identified as stakeholders for examination. BC has regional offices for Child and Family Development, but not regional agencies, therefore there is not a separate stakeholder for social services at the regional level. Though municipalities themselves take on action in response to MHSUD, these actions are generally related to safety. Insofar as municipal governments are not tasked with service provision for youth in the federal ministerial system, municipal policy documents related to MHSUD were not included in this study.

Identification of media. Media reports related to youth MHSUD in specific jurisdictions further inform the policy landscapes in which values of and responses to youth MHSUD are

being shaped. A literature review of media representations of youth MHSUD in the last 10 years in Manitoba as compared to BC served to document changes in public opinion, changes in legislative responses, and were useful to track the kinds of narratives serving advocacy coalitions to determine the deep core beliefs behind policy change. Stories of decline which provide impetus for reform, and stories of control which inspire faith, are narratives that are used to move coalitions forward (Auld & Morris, 2016). Therefore, the document analysis focused on what type of story is being told by the media. Insofar as, Jenkins-Smith and Sabatier (1994) argued that "mapping beliefs and policies on the same canvas permits assessing the influence over time" (p. 180), it is important to document moral influences in different jurisdictions in order to fully assess the policy landscape and changes within it.

In identifying media as a stakeholder, I focused on print media from the Canadian Broadcasting Corporation (CBC) for three reasons: (a) as the CBC is a national news outlet with regional offices, there are similarities in terms of reporting mandates; (b) as a crown corporation, the CBC has a mandate to provide inclusive reporting on the political context of Canada. As per their mandate, the CBC has a role

> "to contribute to the development of a shared national consciousness and identity; to reflect the regional and cultural diversity of Canada; and to contribute to the development of Canadian talent and culture. To achieve its mandate, the CBC/Radio Canada produces, procures, and distributes programming in English, French and eight [Indigenous] languages and broadcasts a selection of programs around the world" (Government of Canada, 2022, first paragraph).

(c) the CBC has print, online and video news coverage in both Manitoba and British Columbia.

NGOs, advocacy groups. Non-governmental organizations (NGOs) and advocacy groups at the regional, provincial, and national levels have the capability to influence policy and legislation. As such, position papers, annual reports, and social media campaigns related to non-governmental organizations in the last 10 years were vital to include in terms of mapping out beliefs across systems and levels of governance. While non-governmental organizations (NGOs) exist at all three levels of governance, their roles are unique at different levels of governance. In the Canadian landscape, federal mental health-related NGOs tend to be rooted in large-scale advocacy, pan-national policy orchestration and data-sharing (for example, the work of Canadian Mental Health Association, Mental Health Commission of Canada and the Canadian Center on Substance Use). Provincially, NGOs take on a different role, as policy sectors run by provincial ministries generally come with funding dollars. Thus, it is common for NGOs to become provincial partners via funding transfers (Ruetz & McKenna, 2021). Manitoba MHSUD partnerships between the Government of Manitoba and the United Way and Strongest Families Institute (Government of Manitoba, 2021; Government of Manitoba, 2022) and British Columba Partners for Mental Health and Addiction and Foundry Centers (Government of British Columbia, 2022) are examples of this. Finally, non-governmental organizations at the regional level tend to be community organizations who have tended to fill gaps in the service-provision landscape. Collins et al (2013) found that at the regional level, NGOs may take on more service-provision roles than they do advocacy roles. Sangeeta (2003) has argued that in addition to NGOs, inquiries into non-governmental actors at the regional level also need to consider CBOs—Community-Based Organizations—which are employed by provincial and regional governments via funding agreements as means to extending service delivery.

Given this context, in drawing a representative sampling of NGO stakeholders, NGOs at the national level, provincial, and regional levels were identified differently for the purposes of this Stakeholder Analysis. At the national level, advocacy-based NGOs hold influential power to advocate. The three most prominent national NGOs include the Canadian Mental Health Association (CMHA), the Mental Health Commission of Canada (MHCC), and the Canadian Center on Substance Abuse (CCSA). The CCSA is also part of federal legislation, via the CCSA Act, so is included as a federal partner rather than as an NGO. Additionally, the CMHA works predominantly on mental health issues without overt work on substance use. Therefore, the MHCC was included as the national-level NGO stakeholder. At the provincial level, key NGOs were included via document analysis of ministerial partnerships, and, thus, were included in the provincial Stakeholder Analysis mapping and document set. Similarly, regional NGOs acting as service providers were identified in analysis of regional service provision networks. A complete list of identified stakeholders for Stakeholder Analysis is listed in Table 4.2.

Target groups – Provincial Advocate reports as a reflection of stakeholders. Provincial Advocates' and Representative's reports present a useful and also under-utilized data set, representing perspectives from youth and impacts of policy subsystems on youth and families. Provincial Advocates are in place in most provinces and territories in Canada, and these offices advocate, review, investigate, research, and examine child-serving systems, including child welfare, mental health, addictions, education, and youth justice (Government of Manitoba, 2023). Manitoba's Children's Advocate was founded in 1992 and British Columbia's Representative for Children and Youth has been in effect since 2006. Advocates' Reports publicly document their investigations and examinations, making recommendations to best support youth. Thus, they are a vital data set to identify the impacts of existing MHSUD policies,

bureaucratic structures, and service provision frameworks for youth. All advocates' reports published in the last 10 years which contain any mention of youth MHSUD were included in the analysis. Identified multi-level and multi-sector stakeholders for inclusion were collated in a single list of stakeholders, shown in Table 4.3.

Table 4.3
Identified Stakeholders in the Policy Subsystem of Youth MHSUD

Type of Stakeholder Group for Stakeholder Analysis	**Policy Actor**	
Federal Governmental Offices	Health Canada (HC) Public Health Agency of Canada (PHAC) Chief Public Health Officer of Canada (CPHO) Indigenous Services Canada (ISC) Public Safety Canada PSC) Canadian Center on Substance Abuse (CCSA) Joint Consortium on School Health (JCSH)	
National Level Indigenous Governance	Assembly of First Nations (AFN)	
Provincial Governmental Offices	**Manitoba**	**British Columbia**
	Ministry of Mental Health and Community Wellness (MB/MMHCW) Manitoba Health (MB/MH) Manitoba Education (MB/ME) Ministry of Families (MB/MF) Addictions Foundation of Manitoba (provincial partnership) (MB/AFM) Healthy Schools Manitoba (provincial partnership) (HSM)	Ministry of Mental Health and Addictions (BC/MMHA) Ministry of Health (BC/MH) Ministry of Education and Childcare (BC/MEC) Ministry of Child and Family Development (BC/MCFD) Healthy Minds, Healthy People (provincial partnership) (HMHP)
Provincial Level Indigenous Governance	Assembly of Manitoba Chiefs (AMC)	British Columbia Assembly of First Nations (BC/AFN)
Regional/Regional Governmental Offices	Winnipeg Regional Health Authority (WRHA) Winnipeg School Division (WSD) Shared Health (MB/SH) Southern Chiefs Organization: Southern First Nations Network of Care (SCO)	Vancouver Coastal Health Authority (VCHA) First Nations Health Authority (FNHA) British Columbia Provincial Health Authority (PHA) Vancouver School Board (VSB) Supporting and Connecting Youth Initiative (SACY)
NGOs/ Advocacy Groups	National: Mental Health Commission of Canada (MHCC) Provincial: Policy Partners as identified within examined provincial governmental documents Regional: Service Providers outlined in regional service provision frameworks	
Media	CBC Print Media 2013-present	CBC Print Media 2013-present
Target Groups	Manitoba Advocate for Children and Youth (MACY)	British Columbia Representative for Children and Youth (BCRCY)

Following this initial collation, identified stakeholders were examined to determine if they took on legislative, service-provision, or advocacy roles to explore the positionality and identified inter-relationality of the stakeholders. The positionality and relationships of the policy actors is explored in the Findings section.

Identification of policy documents. In addition to stakeholder mapping, this study sought to identify existing documentation which would allow for an empirical investigation of stakeholder values in relation to MHSUD stakeholders' interests and beliefs; the policy actions that were taken on behalf of those beliefs; and the partnerships, alliances and cooperatives within the existing policy subsystem. This was done with an intent to review opportunities for and barriers to coordination at the policy integration and/or service provision level. In keeping with Consodine (1994), I understood policy documents to be written actions which employ "authority to commit resources in support of a preferred value" (p. 6). Policy documents may take the form of legislation, position papers, news releases, and program reviews intended to influence future practice, media reports, websites, and other documentation (Rizvi & Lingard, 2009). While policy documents can be seen as documentation of what governments choose and have chosen to do, "policy silences"—places in which governments have not chosen to take action— are also key to examine (Rizvi & Lingard, 2009, p. 14). Taking note, for example, of where MHSUD is not directly addressed provides data on where the policy issue is not being discussed. Thus, a scoping analysis of cross-sector and multi-level policy documentation can serve as a key mechanims to map out action and inaction. Critical Discourse Analysis (Step 2) of these documents can map out underlying coalitions and opportunities for coordination.

Following identification of policy actors, policy documents from each of the identified stakeholders were reviewed in order to identify documents for analysis. Given the vast number of policy documents dealing with substance use and mental health across policy sectors and levels of governance, I developed inclusion criteria that supported a scoping analysis of the policy actions that influence policy *responses* to youth MHSUD. Therefore, it is beyond the scope of this project to include documents which identify individual substance use treatment

facilities, represent public education campaigns related to MHSUD, or provide statistical reports related to prevalence of MHSUD. There is a plethora of policy documentation (particularly at the federal advocacy level) which is intended to provide information to policymakers and lawmakers and to provide public awareness and educational campaigns to the general public. In this project, the literature review, presented in Chapter 2, has already provided a background on the context of MHSUD, the prevalence of MHSUD, the dangers of MHSUD, and the evidence-based practices to support MHSUD. Therefore, only documents that followed a mandate to legislate, influence, or direct responses to and supports for youth MHSUD were included for review. In sum, documents were only included for review if they:

1) were publicly available;
2) had a direct mandate to inform the issue of responses to youth MHSUD; and
3) have either been implemented since 2013, or in the case of formal legislation enacted prior to 2013, remains current. The emergence of socio-ecological models of health—entrenched by Canada's commitment to the World Health Organization's *Rio Political Declaration on Social Determinants of Health* in 2012 (Government of Canada, 2023) was a key turning point in treatment of substance use as a socio-health issue and in 2016 the federal government moved control of the anti-drug strategy from Justice to Health in Parliament. Given this fundamental shift in treatment of MHSUD federally, I thus use a ten-year time period (2013-2023) to examine policy prior to this shift, and in the ten years since this shift.

Additional inclusion criteria for each subset of policy actors are included in the sections below.

Federal policy documents. In my identification of relevant documents for Stakeholder Analysis, I identified federal legislation, directives, reports on best practices, position statements, and other formal documentation developed by the federal stakeholders. To begin with, using key

words such as "substance use," "drug," "mental health and youth," I looked for any federal legislation dealing with responses to youth MHSUD across all sectors of government in Justice Canada's Consolidated Act Archive (https://laws-lois.justice.gc.ca/eng/acts/).[12] Following this initial search for formal legislation methods for determining relevant documents varied by policy sector. In terms of inclusion criteria, Table 4.4 outlines the methods that were used to identify documents for each federal stakeholder, the types of documents that met inclusion criteria, and the types of documents that were excluded from examination. In addition to documents by identified stakeholders, key policy documents related to the provision of Jordan's Principle were also included since, as discussed in Chapter 2, Jordan's Principle provides a funding framework for MHSUD service provision and policy implementation for Indigenous youth, even though MHSUD may not be overtly listed in the policy documents themselves. Statistical documents, public service announcements, or other documents dealing with informational campaigns related to substance use rather than responses and supports within federal systems were deemed beyond the scope of the project.

Table 4.4
Methods and Inclusion for Policy Identification: Federal

Federal Policy Sector Identified	Process for Identification of Documents	Types of Documents Included	Types of Documents Excluded (beyond scope)
Education	No federal ministry	No documents identified	No documents identified
Child Welfare	No federal ministry	No documents identified	No documents identified
Health Canada	Health Canada documents in the Government of Canada publications database (https://publications.gc.ca/site/eng/home.html) to look for documents related to MHSUD Publications and links on the Health Canada website to identify any additional relevant documents for review	• Legislation dealing directly with responses to youth. MHSUD, including service provision recommendations and frameworks • Position papers and outcome reports intended to influence policy responses to MHSUD	• Infographics, public service announcements, awareness campaigns or data reports defining substance use trends or statistics in Canada • Monographs dealing with SUD in adult groups broken down by gender and demographics • Calls for proposals for funding MHSUD projects • Information resources for parents (e.g.: how to talk to your teen about drugs) • Program inventories, including those funded by Health Canada and territorial audit reports • Legislation related to justice-related reports, including: impaired driving, importing/ exporting

[12] It should be noted that while not included in examination, below, there are some overarching pieces of Legislation to be aware of, which provide a framework for MHSUD legislation and service provision. In particular, *An Act Respecting First Nations, Inuit and Metis Children, Youth and Families* (2020) has substantial impact on how the policy documents in the policy subsystem of youth MHSUD are understood and enacted in Canada. Therefore, while this Act does not formally fall into the inclusion criteria for analysis, its importance in terms of the policy context is noted.

		• Framework Documents	• Statistical reports documenting impacts of MHSUD during COVID-19 • Documents dealing with FASD • Financial reports – costs of services • Documents in French • Acts related to drug use, but not to policy responses to youth MHSUD (e.g.: Controlled Drugs and Substances Act, Cannabis Act)
Public Health Agency of Canada	Public Health Agency of Canada documents in the Government of Canada publications database (https://publications.gc.ca/site/eng/home.html) to look for documents related to MHSUD. Publications and links on the Public Health Agency of Canada website to look for any additional relevant documents for review.	• Position Papers/ Guideline Documents	• Documents dealing with other public health issues as primary factors
Chief Public Health Officer of Canada	Review of all documents published by the Chief Public Health Officer of Canada in the Government of Canada publications database (https://publications.gc.ca/site/eng/home.html).	• Position Papers	• Position statements on health issues outside of MHSUD or where MHSUD was a secondary focus.
Public Safety Canada	Search criteria of "youth" in the Public Safety Canada Publications Database (https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/index-en.aspx) , review of all publications to sort for documents dealing with responses to youth MHSUD.	• Program summaries/ reviews of pilot programs funded by federal government in provincial/regional contexts which are intended to influence the policy subsystem and set precedent.	• Initiatives and research where primary focus is gang prevention/crime prevention and not MHSUD response • Statistical/metrics reports related to delinquency and risk-factors related to delinquency • Reports specific to the context of youth MHSUD in conjunction with homelessness, human trafficking, organized crime, impaired driving
Indigenous Services Canada	Review of all publications in Indigenous Services Canada Publications database (https://publications.sac-isc.gc.ca/PubCBW/publication/catalog.aspx?l=E) to sort for any documents that deal with responses to youth MHSUD,	• Framework documents • Federal program initiatives • Jordan's Principle documentation as a pathway to MHSUD supports	• Documents outlining access points for service provision to individuals • Calls for proposals/ allowances of funding • Webpages dedicated to providing additional understanding of existing policy. Documents (where applicable, these documents have been included as primary sources) • Listings of substance use treatment centers
Canadian Center on Substance Abuse (CCSA)	The Canadian Center of Substance Abuse Act legislates that the CCSA takes on roles on behalf of the Government of Canada; review of the CCSA website publications database (https://www.ccsa.ca) to identify documents related to responses to youth MHSUD.	• Publications recommending policy responses to youth MHSUD are included,	• Information campaigns, statistical reports dealing with harms associated with substance use, usage trends, sharing of general research • Reports on scope of youth drug and cannabis use • Environmental scans of existing programs • Statistical reports highlighting patterns in drug use (nationally and by province) • Documents dealing with impaired driving, parent guides for talking to youth, safe consumption sites • Information for service providers and families on systems leadership and patient care • Annual reports, reports on past anti-drug strategies
Assembly of First Nations	Review of the Assembly of First Nations website to look for any documents or publications related to responses to youth MHSUD.	• Co-implemented federal framework document with Indigenous Services • Jordan's Principle policy input	• Service provision information/ sites of access to treatment

Provincial policy documents. At the provincial level, documents reviewed to determine relevancy included: (a) formal policy and legislation; (b) guidelines and standards developed in

support of formal policy, and (c) declarations of intent, strategic directions and reports. Given that the focus of the study is on existing responses and supports for all youth with MHSUD, justice-based documents were excluded. I focused instead on policy and policy documentation in the sectors of Health/Mental Health, Child and Family Services, and Education. Furthermore, given that provinces legislate the majority of sectored responses to MHSUD, it was important to consider the ways in which policy/legislation supporting multi-sector responses to at-risk youth (for example, youth in care) might also inform multi-sector responses to MHSUD. Therefore, at the provincial level, in addition to policy/legislation dealing directly with youth MHSUD, I included key documentation in which youth MHSUD was mentioned peripherally or where MHSUD falls within service provision mandates, even if it was not the primary focus of the document. For example, in Manitoba, the *Health System Transformation Plan* (2020) followed a provincial policy assessment document that was undertaken by independent consultant with report to Ministry of Health (known as the *Peachy Report*, 2017). Additional documents included a Program Charter (2020) and other logistical documents supported governance of the Health System Transformation plan. However, it is the Health System Transformation Plan (2020) itself, which maps out responses to MHSUD provincially in Manitoba. Therefore, only this document with significant emphasis on MHSUD, rather than detailed health care administration data was included as a policy document influencing MHSUD responses. That is, given that the intent of the *Peachy Report* was broad health service delivery, only the final policy implementation of Health Transformation, where attention is paid to MHSUD, is part of the policy analysis at the provincial level. Similarly, strategic plans and service plans for health authorities tended to be published on three to five year rotations. Insofar as the goal of this project was to map out broader system change, I included only the most recent plan as a measure

of how shifting mandates, directives, and legislation are permeating current service provision for MHSUD. In addition, I included provincial-level Indigenous governance documentation on mental health care provision in general, and youth MHSUD, in particular.

To begin with, I looked for any provincial Acts or Regulations dealing with responses to youth MHSUD (where key words included "youth," "substance use," "drugs," and "mental health") across all sectors of government via the Manitoba Laws website (https://web2.gov.mb.ca/laws/index.php). Following this initial search, formal legislation methods for determining relevant documents varied by policy sector. Table 4.5 outlines the methods that were used to identify documents for each provincial stakeholder, as well as the types of documents that met and did not meet inclusion criteria.

Table 4.5
Methods for Inclusion and Policy Identification: Provincial

Provincial Policy Stakeholder (Manitoba/British Columbia)	Process for Identification of Documents	Types of Documents Included	Types of Documents Excluded
Mental Health and Community Wellness/ Mental Health and Addiction	Review of ministerial websites to identify reports, websites, legislation and publications directed at responses and supports for youth with MHSUD.	• Legislation • Press Releases • Framework documents • Website (as an artifact of service delivery framework)	• Harms and info data • Health promotion, smoking cessation, vaping information. • Websites on specific service providers. • Standards for directors of mental health institutions.
Ministries of Health	Review of ministerial websites to identify reports, websites, legislation and publications directed at responses and supports for youth with MHSUD.	• Legislation • Press Releases • Framework documents • Consultative reports leading up to legislative change where MHSUD is the primary issue	• Preliminary consultative reports leading up to legislative change where MHSUD is a peripheral issue and not a primary issue in the consultative commissioned reports.
Manitoba Education/ British Columbia Education	Review of Ministry of Education websites and publications databases to look for relevant documents.	• Legislation • Safe Schools Publications • Inclusive programming guideline documents • Policy documents directing responses to students with additional needs.[13]	• Curriculum documents where information about substance use is part of the curriculum • Websites to support curriculum documents which have info links for students and parents about drugs and alcohol (in most cases, links to CCSA publications), including myths and facts. • Safe schools documentation dealing with issues other than MHSUD
Child and Family Services (Manitoba)/	Review of ministerial websites to identify publications related to	• Legislation • Standards manuals	• Discussion of controlled substances where the primary policy area is child trafficking

[13] In both the Safe Schools documents outlining guidelines for safety in schools and appropriate education planning documents, which outline for school staff how to respond to youth with additional needs, substance use is not mentioned directly. However, the documents speak directly to cross-policy work to support youth, so are included in this data set.

Child and Family Development (BC)	MHSUD outside of formal Acts and Regulations.	• Policy framework documents	• Intoxicated Persons Detention Act • Documents dealing with parental substance use • Press releases that outline services already included in the data set • Information on specific service providers
Assembly of Manitoba Chiefs	Review of website and publications databases to look for relevant documents.	• Any discussion of responses to MHSUD including service provision, funding, culturally-relevant responses	• Health care discussions outside of MHSUD
British Columbia Assembly of First Nations	Review of website and publications databases to look for relevant documents.	• Any discussion of responses to MHSUD including service provision, funding, culturally-relevant responses	• Health care discussions outside of MHSUD

***Regional policy documents*.** For each of the identified regional stakeholders, I again included policy documentation dealing with responses to youth MHSUD. In the cases where regional responses may splinter into multiple service providers at the regional level, I only included documentation that mapped out the pathways and partners in these service provision networks. The scope of this study is not to investigate the plethora of service provision access points at regional levels, but rather to explicate the response pathways that are built into the policy subsystem. Table 4.6 outlines the methods that were used to identify documents for each regional stakeholder, as well as the types of documents that met inclusion criteria.

Table 4.6
Methods for Inclusion and Policy Identification: Regional

Regional Stakeholders (Winnipeg/ Vancouver)	Process for Identification of Documents	Types of Documents Included	Types of Documents Excluded
Winnipeg Regional Health Authority / Shared Health(WRHA)	Review of WRHA website to identify: reports and publications, regional policies and informational sections of website(s) that speak to service delivery frameworks.	• Websites with health provision dealing with mental health • Community assessments • Most recent strategic plan documents	• Individual service providers • Health provision outside MHSUD • Governance documents where primary focus is on broad health governance
Winnipeg School Division (WSD)	Review of WSD website to identify: reports and publications, regional policies and informational sections of website(s) that speak to service delivery frameworks.	• Policy Documents • Website	• Curriculum references
Southern First Nations Network (SFNN)	Review of SFNN website to identify: reports and publications, regional policies and informational sections of website(s) that speak to service delivery frameworks.	• Website outlining MHSUD service provision	• Individual service providers • Health provision outside MHSUD
Vancouver Coastal Health Authority, BC Provincial	Review of website to identify: reports and publications, regional policies and informational sections of website(s) that speak to service delivery frameworks.	• Website outlining MHSUD service provision	• Individual service providers • Health provision outside MHSUD

Health Authority, First Nations Health Authority		• Strategic Plans and Service Plans (most recent)	
Vancouver School Board (VSB)	Review of VSB website to identify: reports and publications, regional policies and informational sections of website(s) that speak to service delivery frameworks.	• Website • Policy documents • Regional partnerships • Procedures manual	• Curriculum references
BC Regional CFS Agency	None identified – run provincially	None identified – run provincially	None identified – run provincially

Non-governmental organization documents. As per the inclusion criteria, the Mental Health Commission of Canada (MHCC) was identified as the national-level NGO stakeholder for the purposes of this study. At the provincial level, key NGOs were included via ministerial partnerships, and, thus, were included in the provincial stakeholder and document set. Similarly, key regional NGOs acting as service providers were identified in analysis of regional service provision networks. To identify MHCC policy documents, I reviewed all reports/publications on the MHCC website and reviewed the website in general to identify documents meeting inclusion criteria. For provincial and regional level NGOs, no additional stakeholders and documents had to be identified, as documents have been identified at the provincial and regional levels alongside provincial ministerial partnerships and regional service provision networks.

Media documents. As discussed earlier, in reviewing media reports I focused on print media from the Canadian Broadcast Corporation in the regional offices of Winnipeg and Vancouver, in keeping with the two jurisdictions being analyzed. In order to identify articles for examination, I visited the CBC Manitoba website (CBC Manitoba, 2023) and the CBC Vancouver website (CBC Vancouver, 2023) and used key words of "youth substance use" and "youth mental health" to search for potential resources. Media reports on access to substance use services and responses youth MHSUD were included for examination. Media reports on prevalence of substance use, hospitalization numbers, overdose data, financial reports, personal stories of life after recovery, warning about new drugs, and news stories dealing with justice-

related response to MHSUD such as decriminalization, safe-injection sites, and safe supply campaigns were deemed beyond scope of this project.

Provincial Advocate documents. In identifying Advocate reports for consideration, the publications database on both provincial Advocate office websites was utilized to identify documents. I reviewed all publications and any reports dealing with MHSUD or child welfare/system navigation in general were included. Specific reports/publications related to policy sectors outside MHSUD and service provision, reports/publications related to youth in the justice system, and reports/publications related to youth with disabilities were excluded. Given these criteria, a full list of policy documents, organized by level of governance and stakeholder, was compiled as a database of identified documents.

Step 2: Document Analysis Informed by ACF Stakeholder Analysis

Within complex multi-level systems, ACF has been used as part of a diverse set of analytic approaches, including empirically testing the existence of coalitions in particular policy subsystems, mapping policy-oriented learnings of coalitions over time, and testing the hierarchical nature of deep core beliefs (Heinmillar, 2016). However, in this study, I take up, in line with Heinmillar (2016), ACF as "research to specify the micro-foundations of advocacy coalitions by focussing on their two defining features: shared policy core beliefs and collective action" (p. 25). That is, I used ACF as a means to investigate the stakeholders within policy subsystems that seem to be influencing particular agendas at different levels of governance. My goal was to uncover alignments and misalignments in deep core beliefs, to compare those beliefs with other jurisdictions, and to find pathways forward for policy alignment, coordination, and integration that would allow for support for students across policy sectors.

From an ACF standpoint, Stakeholder Analysis is a useful method to employ in investigating alignment, as it:

> provides a guide to investigate stakeholders' perceptions regarding the severity, causes, and proposals of a problem, the distribution of resources among coalitions, and the accessible political venues for influencing policy. This helps policy analysts, leaders, and other stakeholders identify political roadblocks, develop strategies for achieving objectives, and find paths to collective agreements. (Weible, 2006, p. 97)

This type of analysis allows for an explication of which policy core beliefs have been included in the framing of a problem and which have been excluded. By focusing on how policy problems have been informed, framed, implemented, and reviewed by stakeholders in the policy subsystem of youth/student MHSUD, analysis allows focusing on the value positions and advocacy coalitions exerting control in particular areas of that policy subsystem. These core beliefs of MHSUD as a policy issue then inform the secondary beliefs—the policy interests and policy goals that are supported by stakeholders.

In this project, I extend an ACF Stakeholder Analysis to identify instances of policy alignment and policy learning, and also to identify opportunities for increased policy coordination. In this step of the methods, document analysis utilizing CDA served to examine the language used in policy documents to answer the six questions identified as part of the ACF Stakeholder Analysis. Drawing on Weible (2006), and in line with other researchers (Brugha & Varvasovsky, 2000; Crosby, 1991; Susskind & Thomas-Larmer, 1999), I utilized Stakeholder Analysis as a method which investigates key discourses in a policy subsystem. In particular, following an identification of key stakeholders in a policy subsystem, these questions [in keeping with Weible (2006)] include:

1) What are the stakeholders' interests and beliefs in relation to MHSUD?
2) What actions are employed in support of these interests and beliefs? Who controls critical resources? What strategies and venues do stakeholders use to achieve their objectives?
3) With whom do stakeholders form coalitions?

And to this initial question, I add:

4) what are the opportunities for and barriers to coordination at the policy and/or service provision level?

Given this framework of ACF Stakeholder Analysis, my data analysis identified discourses that supported these identified questions. Thus, using CDA, the following were identified:

1) Discourses of Intent: which were used as a construct to mark both stakeholders' interests and beliefs regarding policy responses to MHSUD. In particular,
    i) Stakeholder interests—which are directy related to policy positions (Weible, 2007)—were identified through CDA to describe secondary beliefs or how policy ought to respond to MHSUD in support of stakeholder interests.
    ii) Stakeholder beliefs—conceptualizations of MHSUD as a policy issue connected to deep core beliefs were seen as the "underlying motivations to influence policy" (Weible, 2007, p. 98).

    Thus, conceptualizations of MHSUD to identify discourses of intent were collected and collated through CDA as a means to identify ideations of MHSUD, grounded in deep core beliefs, that supported particular secondary beliefs.

2) Discourses of Action: Which were used to identify what discourses are used to describe resources, strategies and venues that are being leveraged? Who controls these resources? At what level? Are they symbolic or material?
3) Discourses of Coordination: Which were used to uncover which discourses are used to describe existing coalitions and coordination already demonstrated in the document? Are those vertical or horizontal? What are identified opportunities for and barriers to coordination at the policy and/or service provision level?

Critical Discourse Analysis (CDA) was used as a data analysis tool to support the ACF. I used CDA as a tool to uncover discourses within texts and utilize "a qualitative approach for critically describing, interpreting and explaining the ways in which discourses construct, maintain and legitimize social inequalities" (Mullet, 2018, p. 115). CDA "combines linguistic analysis and social theory to address the way power and dominance are enacted and reproduced in text" (Leotti et al., 2021, p. 1). I took up CDA from the perspective of the ACF, which is concerned with how "individuals, groups and communities collectively make sense of socially relevant or problematic issues" (Markova, 2008, p. 483). If we consider discourses as "linguistic enactment[s] of power" (Mullet, 2018, p. 119), CDA operates under the assumption that the discourses of institutions, and particularly those governments employ, can serve to act as "gatekeepers to discursive resources" (Mullet, 2018, p. 117). Thus, first identifying the language of lived experience before moving onto an examination of policy documents is important.

In this study, I am guided by Fairclough's (2001) dialectical relational approach to CDA, which investigates the "particular aspects of the social process [that] give rise to developments of theory and method which shift the boundaries between different theories and methods" (p. 231). Fairclough understood language to be an integral part of the social process and focuses on

semiosis—the process of signification and meaning-making in language—as a driving factor in social action. From an understanding of semiosis in policy, I used CDA as a means to identify the ways in which policy actors utilize policy documents to enforce social significance of their own policy actions. Fairclough (2001) argued that semiosis, the process by which language takes on social significance and power, takes place in three ways: (1) language can become entrenched as part of a social activity within a practice; (2) social actors can produce representations of other practices and their own practices through specific chosen discourses; and (3) the performance of particular social actors with prominent social positioning can carry meaning. These processes of semiosis result in "social practices [being] networked in a particular way [to] constitute a social order" (Fairclough, 2001, p. 232). The process by which discourses take on social meaning and hegemony in the social order, results in value-laden discourses being woven into policy documents in ways that may not always be immediately evident. Thus, Fairclough's (2001) interpretation of CDA serves as a crucial mechanism to uncover the values underlying language, which have dialectically framed social responses to complex issues and provides an opportunity to reflect if other discourses and social actions ought to be considered in particular contexts. Hegemonic discourses regarding a policy area serve to map out possibilities for actions but also limit alternative possibilities. Unless we are mindful of the discourses being used, we cannot move forward with alternate actions (Laclau & Mouffe, 1985).

Collection and collation of discourses for governmental stakeholders. Within identified pool of stakeholdes and documents from Step 1, I collected and coded signifiers (a linguistic symbol, typically a word/phrase to convey meaning) working through identified governmental stakeholder groups, as outlined in Table 4.7, below.

Table 4.7
Governmental Stakeholder Groups: Order of Analysis

a. Federal and cross-national stakeholder documentation

b.	Manitoban provincial stakeholder documentation
c.	British Columbia provincial stakeholder documentation
d.	Manitoba – regional stakeholder documentation
e.	British Columbia – regional stakeholder documentation

Signifiers were coded and collected to identify discourses of intent, discourses of action and discourses of coordination, in keeping with the identified Stakeholder Analysis framework discussed above. Signifiers were identified for each of these discourses using the Signifier and Discourse Collection Tool—Table 4.8.

Table 4.8
Signifier and Discourse Collection Tool

				Discourses of Intent:		**Discourses of Action:**	**Discourses of Coordination:**	
Level of Governance	**Stakeholder**	**#**	Title of Document	What discourses are used to frame stakeholder interests about responses to MHSUD?	How is MHSUD con-ceptualized in service of this policy response? What beliefs guide the response?	What resources, strategies and venues are being leveraged? Who controls these resources? At what level? Are they symbolic or material?	Where are existing coalitions and coordination already demonstrated in the document? Vertical or horizontal?	What are identified opportunities for and barriers to coordination at the policy and/or service provision level?
Stakeholder documents	Name of organization, program, office or ministry			Collection of signifiers	Collection of signifiers	Collection of signifiers	Collection of signifiers	Collection of signifiers

By collecting signifiers for each document in each of these categories, it set the stage for comparisons between levels of government, sectors of government, and between governmental actors and NGOs by providing similar data sets for all stakeholder groups. Each of these data-collection categories are unpacked more robustly below:

Discourses of intent (as a measure of interests and beliefs). I used Critical Discourse Analysis (CDA) to code signifiers related to stakeholder interests and beliefs in order to formulate discourses of intent as an umbrella indicator of these interests and beliefs. First, I identified signifiers related to stakeholders' interests regarding responses to MHSUD in the policy system and collected these signifiers on the data collection tool. Signifiers were then used

to develop themes that I coded as "discourses of intent." For each document I identified interests regarding policy goals associated with youth MHSUD, which led to the identification of a primary policy interest and intent related to MHSUD. For example, increasing "life expectancy… [and] improv[ing] health of Canadians" (CPHO, 2018, p. 3) was coded as an intent to support MHSUD via public health responses. From an ACF perspective, secondary beliefs are understood as policy preferences, or the interests set out by stakeholder groups to solve a particular understanding of a policy problem. Thus, the identified discourses of intent serve to illuminate the secondary beliefs within the examined policy subsystems (Auld & Morris, 2016) and also to identify the deep core beliefs about MHSUD that support these policy actions.

While all examined documents had an identified primary discourse of intent, some documents touched on secondary discourses of intent. For example, documents, whose primary intent was determined to be prioritizing harm reduction (rooted in a socio-ecological model of health), in some cases also contained discourses of public health—for example, discussions of mortality rates and life expectancy. Similarly, documents' whose primary discourse of intent was "prevention" sometimes also listed prevention of harms as a policy goal. In most cases, these secondary and tertiary discourses were determined to be part of a larger identification of the primary discourse of belief and, thus, the document was coded by the primary discourse theme only. The exception to this was when a secondary discourse of intent touched on a completely separate goal to the primary discourse. This happened most notably when documents listed health or safety goals as primary intents, and financial savings as separate discourses of intent. These discourses were noted separately in the tables and in the analysis.

Supporting an analysis of discourses of intent, I also collected signifiers and coded for underlying conceptualizations of MHSUD within the policy documents—deep core beliefs.

Uncovering conceptualizations of MHSUD is a means to identify policy cores—that is, underlying beliefs about the underlying causes of a problem—that are used to justify particular secondary beliefs (Auld & Morris, 2016). For example, MHSUD as an issue "profoundly shaped by influences that extend far beyond their personal traits and immediate situation" (PHAC, 2022, p. 17) was coded as a conceptualization of MHSUD as a symptom of socio-ecological health (core belief), which underscored a discourse of intent to minimize harms from MHSUD by treatment as a cross-sector issue (secondary belief/ discourse of intent). In ACF, policy actions themselves are understood to be rooted in common policy goals, which are entrenched in deep-core beliefs about the policy problem (Jenkins & Sabatier-Smith, 1994). Therefore, an examination of discourses of intent serves to illuminate and compare policy interests (associated with secondary beliefs) alongside conceptualizations of MHSUD (associated with core beliefs) in order to uncover the interests and beliefs that are grounding actual policy actions.

Discourses of action. Next, I collated and codified signifiers to identify actions or commitments to action inherent in the documents. In keeping with Rizvi and Lingard's (2009) work on policy implementation, for each of the policy actions identified in the documents, I identified them as either material (legislative or service-provisional) or symbolic (advocacy based) policy actions. Rizvi and Lingard (2009) argued that material policies include actionable commitments to implementation including sanctions, funding of implemented models of service provision. Symbolic policy actions include political responses without material heft to them, intended to legitimize particular views. Policy actions and the types of policy actions were collated by policy actor within the pre-collated discourses of intent. In this way, the actions supporting specific discourses of intent were explicated for comparison.

Discourses of coordination. Finally, I identified existing discourses of coordination. Drawing on the policy coordination research outlined in Chapter 2, I collected and coded signifiers related to four areas demonstrating existing stakeholder coalitions and further opportunities for policy coordination:

(a) Type of coordination. Specifically, whether the coordination outlined in the document is vertical or horizontal, and if it is supported through imposed structures (coercion), purposeful alliances (cooperation) or mutual adjustments (competition).

(b) Degree of implementation. That is, whether the cooperation is at the service-provision level or if it indicates a higher level of policy integration with trans-domain goals through either (i) a blend of existing policies into a unified whole; or (ii) an incorporation of one policy area into another to make a unified framework.

(c) Catalysts and barriers to coordination. In this case, I drew on the literature review on policy coordination in Chapter 2 to examine key evidence-based catalysts to and barriers to policy coordination. The literature review deemed some catalysts and barriers to coordination as being located externally to a policy system: namely economic factors, political factors and ideational factors which are all rooted in external perturbations. While there has been some reference to these external perturbations in the scope of this study[14], in this particular step of the methodology, my interest was in unpacking characteristics internal to the policy subsystem which may affect the ability for policy actors to coordinate actions. In this case, four key indicators formed the research base. First, there is a consensus that ideational cohesion (Wallner, 2017)—also called common goals, a shared vision (Jessop, 2004), first order principles (Hogle & Nordbeck, 2012; Peters 2015) and external coordination via moral contracts (Brian, 2008)—is a

[14] For example: politics, ideational change, economics, and covid

vital catalyst to policy coordination. The shared argument here is that independent bodies in pursuit of a shared goal are more likely to find purpose in working together. Second, the necessity to have all policy actors present at the planning stage is cited by several authors (Peters, 2015; Wietkoritcz, 2001) as being important as "public sector organizations… protect their areas of interest and avoid policy risks" (Jungblut & Rexe, 2017, p. 52) and, thus, vested interests in a policy outcome is important. Third, research demonstrates that if planning and budget are determined at different levels, there are no clear incentives to align (Weitkorowicz, 2001). Related to this, criteria for decision-making at the grass-roots level of policy implementation is often different than at decision-making level, resulting in dangers to coordination based on misaligned understandings (Peters, 2015). Thus, decision-making with good understanding of grass roots realities and decision making at the same level of funding provision, are key. These four evidence-based catalysts to or barriers for coordination are aligned with Hogl and Nordbeck's (2012) understanding of necessary components for successful policy integration, where: (a) comprehensiveness can be understood as presence of shared vision and all policy actors at the planning stage; (b) aggregation is understood to include the evaluation of alternatives to ensure fidelity of implementation; and (c) consistency takes the form of ensuring policy actions and funding are in accord with others. Given this evidence base in the literature, I coded for signifiers demonstrating the presence of:

1) shared values with other sectors/jurisdictions or lack of shared values;
2) mechanisms to monitor fidelity of implementation at grass roots levels, or lack mechanisms to monitor fidelity of implementation;
3) funding mechanisms at the same level of governance, or the presence of funding decisions at different levels;

the presence of all policy actors at the planning stage for policy or the lack of presence of policy actors at the policy making stage.

As discussed above, documents were examined within a particular level or jurisdiction of governance first. Beginning with federal stakeholder and documents, collection of signifiers was used to first examine discourses of intent (as a measure of policy intents and beliefs), action and coordination. Themes within single levels of governance are examined first and are outlined in Chapter 5: Analysis.

Collection and collation of discourses for non-governmental stakeholders. Following the coding and collation of government documents, as seen above, I turned my attention to non-governmental stakeholders, which included documents from the identified federal NGO—Mental Health Commission of Canada (MHCC)—media reports, and the Provincial Advocates' or Representatives' reports.

Table 4.9
Non-Governmental Stakeholder Groups: Order of Analysis

a. Identified interest groups and NGOs
b. Media
c. Provincial Advocates' Reports

As discussed earlier, the MHCC was chosen as the federal NGO for review by virtue of its ongoing liaison work with the federal government and their work on both mental health and substance use issues. Though there are also NGOs and CBOs at the provincial level, these were included via provincial partnerships and service delivery frameworks mentioned above. They were also represented in media reports and Advocates' reports examined in this section.

Collation of discourses for these three non-governmental actors took a different form by virtue of their unique role in the policy subsystem. Governmental actors are charting policy actions within the policy subsystem, and, thus, it follows to investigate the interests, beliefs

actions, and coalitions that are inherent in these policy documents. By comparison, non-governmental actors take on roles which intend: (1) to report on or draw attention to commitments to interests, beliefs, actions, or coalitions by policy actors; and/or (2) to critique existing policy intents, actions, and coalitions and prompt civil reforms (Augustin, 2002). Therefore, in coding for signifiers and collating data from these sources, my methods focused on categorizing:

1) The stakeholders (governmental and non-governmental) represented in the document;
2) The existing policy subsystem interests, beliefs, actions and stakeholders that are represented in the document;
3) Critiques of the existing policy subsystem actions and coalitions;
4) Strategies and recommendations to the policy actors moving forward.

Data was collected and coded using Table 4.10: Non-Governmental Stakeholder Analysis Tool.

Table 4.10
Non-Governmental Stakeholder Analysis Tool

Critiques of existing values, strategies and coalitions in the existing subsystem of youth MHSUD responses				
Document #	**Stakeholder(s) represented** and positioning of the article	Existing policy subsystem actions and coalitions represented	Critiques of existing policy subsystem actions and coalitions	Strategies and coalitions recommended
# Purple documents identify governmental critiques	**Name of stakeholder(s) represented in the policy documents** *Purpose or context of the policy document – what is being critiqued .*	Collection of signifiers	Collection of signifiers	Collection of signifiers
# Pale yellow signifies documents supporting governmental actions	**Name of stakeholder(s) represented in the policy documents** *Purpose or context of the policy document – what policy action is being referenced.*	Collection of signifiers	Collection of signifiers	Collection of signifiers

Step 3: Analysis of Themes

Following collection, coding, and collation of these discourses for each data set, themes were analyzed within data sets. Cassels (2001) has argued that "policy text[s] [are] best understood as a social act, a product of the socio-political and historical context in which it exists" (p. 271). That is, policy documents themselves have the power to convey social

underpinnings and should be examined against lived experience to investigate their efficacy and the deep core beliefs they reflect. Themes related to discourses of belief, discourses of action, and discourses of coordination were drawn from the data and examined.

Step 4: Findings and Cross-comparison of Data Sets

Next, a comparison of the discourses used within sectors, between sectors, between jurisdictions, and between levels of governance was completed in service of answering the research questions. Cross-case comparison and analysis of findings are intended to support an examination of existing values and beliefs, existing cross-sector and multi-level coordination, barriers to coordination, and opportunities for improved coordination to support youth.

Step 5: Recommendations

Following a presentation of key themes and findings, I drew out most important key findings to highlight recommendations that have the potential to improve policy coordination and better meet the needs of students requiring MHSUD supports.

Methodological Limitations

The methodological limitations of this study reside primarily in its positioning as a qualitative analysis which included subjective analysis of data. My own positionality as a researcher and school administrator seeking to identify cross-sector and collaborative supports for youth in schools means that I interpret and code data differently than someone seeking to reduce the financial burden of MHSUD or streamline single-sector responses. Therefore, this analysis of data may not be duplicated by a different researcher with different positionality.

Additionally, it should be noted that this is not a scoping analysis of every policy document or advocacy document related to MHSUD. As discussed above, my focus is on identifying MLG structures that inform policy subsystems for MHSUD and to complete a representative analysis. Therefore, there may be other policy documents not included in the data set which would add or subtract from portions of my data analysis given my data set. Similarly, this research project is not intended as a gap analysis or an inventory of all MHSUD service provision pathways in Manitoban and BC jurisdictions. Finally, this research does not serve to evaluate the impact or outcomes of policy mandates in either jurisdiction. Rather, it is intended to provide a birds-eye analysis of the MLG policy structures that inform how policy is enacted on and with youth.

Furthermore, in policy inquiries utilizing ACF as a conceptual framework, it should also be noted that, "ACF in the form developed by Sabatier and others [cannot] offer satisfactory insights into important aspects of policy-making such as the mechanisms of ratification or rejection of policy options" (Howlett et al., 2017, p. 4). That is, critics have argued that ACF cannot match the scope and range of other approaches to policy such as the policy cycle approach, or applications of MLG inquiries which can bring insights into processes of ratification, by which I mean the decisions that are made and enacted in real time to determine final policy renditions over others. In this sense, Howlett et al. (2017) argued for a combination of ACF with other analytical frameworks, or the utilization of ACF theory as a theoretical perspective and employed with a combination of other analytical frameworks. By focusing on how policy problems have been informed, framed, implemented, and reviewed, future analysis can focus on any one of the functions of the policy cycle to identify unproblematized

perspectives, uncover alternate modes of policy implementation, or to identify new sources of information in order to inform a review process, but that is not the goal of this particular project.

Finally, it should be noted that in my identification of documents for analysis, I was often limited by the availability of search engines or databases for the stakeholders I was identifying. For example, at the federal level, there are inventories of publications online but in searching for documents that met inclusion criteria, I was limited by the information provided to me via the publications databases. Similarly, in identifying media articles, I was limited by the CBC search function online, based on the search criteria entered and the date the search was undertaken. That is, in service of my representational sampling of documents, the individual databases I used to search for relevant documents formed a limitation related to the collation of documents represented in that database.

Conclusion

A qualitative case study approach was utilized as a methodology in order to work through underlying themes and discourses in a large data set of policy actions. Stakeholder Analysis with stakeholder mapping and document analysis with Critical Discourse Analysis using MLG as a conceptual approach and ACF as an analytical lens provide a structure through which to catalogue discourses in documents comparatively. This research thus serves to explicate a vast number of policy directives, value positions, allocations of resources, and opportunities for coordination to better support school-based responses to youth MHSUD. By mapping out and examining the discourses, actions, and coalitions present in policy documentation, disconnects and opportunities for coordination were identified. While the policy context in Manitoba is the primary jurisdiction of analysis, British Columbia was used as a comparator to identify

alternative policy arrangements. As identified in the literature review, there is ample research to support the need for policy coordination in multi-sector issues and also ample research outlining the types of mechanisms that best support such coordination. By looking at the specific policy actors and policy documents mandating action (and identifying inaction) in Canada's federalist system, an analysis of the policy and legislation at work in Manitoba provides some direction with regards to how policy coordination can best (or better) be supported in the Manitoban context.

Chapter 5: Analysis

In terms of the research questions presented, the following three questions are answered in this chapter, in line with the Stakeholder Analysis methods:

1) What policy stakeholders and corresponding documents currently guide responses to youth MHSUD in Manitoba and British Columbia in general, and school-based responses in particular?
2) What are the interests, beliefs, policy actions, and coordination mechanisms that are implicit and explicit in these documents?
3) What are the documented impacts of the current policy landscape for youth in both jurisdictions?

I, thus, present findings in three sections:

1) A collation and analysis of the stakeholders and corresponding documents that are included for examination in line with the methods in Chapter 4 (stakeholder mapping), including discussion of the positionality of these policy actors;
2) A collection of signifiers using Critical Discourse Analysis to identify policy discourses composed of intents (interests and beliefs), actions, and coordination in governmental documents;
3) A collection of signifiers from non-governmental policy documents to inform an understanding of the impacts of policy actions on the examined policy subsystems.

Stakeholders, Documents, and Positioning of Policy Actors/Actions

As discussed in Chapter 4, identification of policy actors and related policy documents in the policy subsystem of MHSUD form a foundation through which to examine policy intents

(interests and beliefs), actions, and coordination mechanisms in specific levels of governance, sectors of governance and jurisdictions. Policy actors included for examination have been shown in Table 4.3. In this section, I examine the positionality of identified policy actors, and using the inclusion criteria in Chapter 4, identify specific policy documents for review. Following identification of policy actors, I turn to identifying policy documents from these actors to inform a Stakeholder Analysis and uncover the beliefs and policy actions that are part of the current policy landscape. This Stakeholder Analysis serves to identify opportunities for policy coordination to better serve youth with MHSUD.

Policy Stakeholders and Their Positioning.

Following the identification of stakeholders (shown in Table 4.3), I identified governance structures and contextual forces that these stakeholders are bound by, using a MLG approach to consider who stakeholders are in the context of Canadian federalism. This approach allows for an exploration the level of influence specific actors wield in the policy subsystem of youth MHSUD. In ACF examinations, consideration of power and positionality of policy actors is key as it informs which values and beliefs are backed by policy actions with more or less influence (Auld & Morris, 2010). Thus, it is also important to identify the type of policy actions that are inherent in policy documents. Dobuzinskis et al. (2005) have argued that policy actors fall into three types of communities, related to their positinality and the type of influence they have on a policy subsystem. These include: (a) actors with "authority to make policy decisions" (p. 3) such as parliaments and legislatures and other senior officials who delegate decision making to others; (b) actors who work as "knowledge generators" (p. 4) who provide data and analysis to influence those who make decisions; and (c) knowledge brokers who repackage data

into useable forms. These policy actors impact the policy subsystem from different roles, but with the shared goal of influencing policy. Similarly, Rizvi and Lingard (2009) argued that once implemented, policy and legislation takes the form of either symbolic policies—political responses, rather than action-based responses, which serve primarily as attempts to legitimize particular views—and material policies—which may be legislative nature, via directives and commitments to implementation, or which may be service-provisional in nature, in the form of direct service provision. Thus, in understanding policy actions at play in policy-subsystems, I identify the roles policy actors play by placing them into three categories: policy actors taking on legislative actions (material), service-provisory actions (material), and advocacy-based actions (symbolic). Legislative stakeholders mandate how services are funded and provided, while service-provisory stakeholders make decisions about how to offer services within the legislative framework. I keep with the colour-coding for stakeholders identified above, and also add additional colour-coding for types of policy actions, as shown in Table 5.1.

Table 5.1
Colour-coding for Policy Actions in Tables

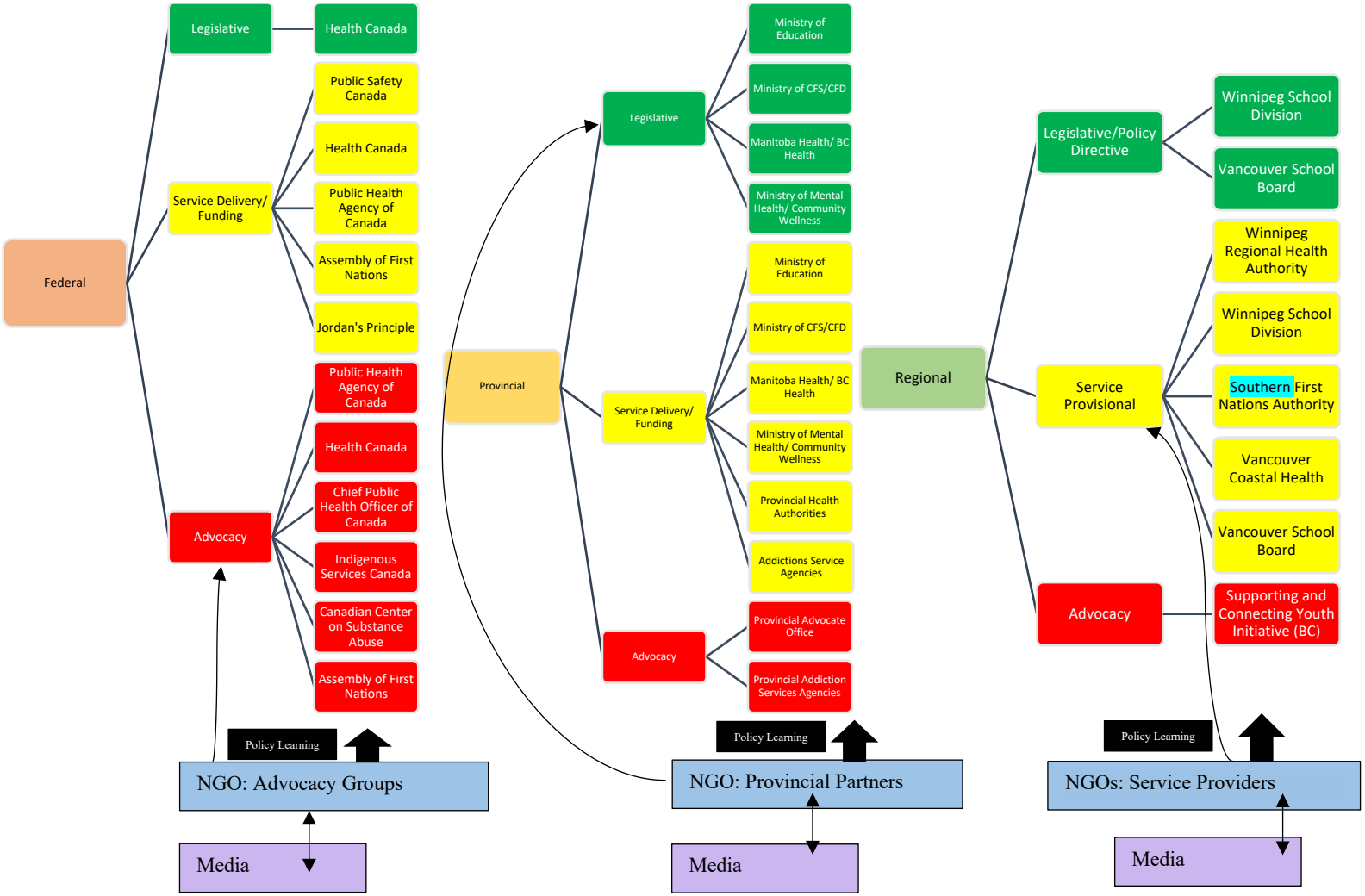
Legislative actions
Service-provisional actions
Advocacy-based actions

Table 5.2 outlines the types of actions identified stakeholders take on at each level of governance. As shown in Table 5.2, at the federal level, only Health Canada takes on a legislative influence in the policy subsystem of youth MHSUD. Though there are other federal offices involved in the policy subsystem, these actors hold advocacy and service-provisional/funding roles. Provincial ministries of Health, Mental Health, Families and Education hold legislative power but also some management of service provision. Governmental actors working in an advocacy role are limited at the provincial and regional levels as these

levels of governance take the lead on action and policy implementation in the federalist system. At the regional level, most policy actors contribute to the policy landscape at a service-provisional level enacting provincial legislation spurred on by provincial funding mechanisms.

As discussed in Chapter 4, in the policy subsystem of MHSUD, NGOs take on unique roles at different levels of governance. At the federal level, NGOs primarily take on advocacy roles gathering evidence and research to package into policy-influencing data sets, while at the provincial level, NGOs are less common and tend to be employed as provincial partners through shared initiatives in legislation and policy (Ruetz & McKenna, 2021). At the regional level, NGOs primarily support service provision (Collins et al., 2013) though this often also includes local advocacy in support of regional service provision (Sangeeta, 2003).

Table 5.2 –Mapping of Multi-Level MHSUD Stakeholders Based on Influence



As demonstrated in Table 5.2, nongovernmental policy actors such as NGOs, advocacy groups, target groups, and the media have indirect influence on governance, insofar as they are not legislating policy responses. However, from an ACF perspective, these groups have the ability to influence policy actions and policy change, particularly when there are external perturbations to a policy subsystem (for example, a change in governance), and when there are significant shifts in values around a policy area due to policy learning, which contributes to policy bifurcation (Hogl & Nordbeck, 2012; Jenkins & Sabatier-Smith, 1994). Each stakeholder at the regional level has a different type of influence. Advocates' offices are provincially legislated to report to provincial governments with recommendations for child-serving systems. NGOs are generally tied to a particular value position and are enacted in order to support service provision and influence policy to align with that value position. Media, on the other hand, serve as a tool, where coalitions with particular policy views may "[secure] allies in the media to help mobilize the attentive public" (Haar et al., 2021, p. 1772). In the case of either external perturbations to a policy subsystems or policy learning within a policy subsystem, then, the voice of the media to influence policy beliefs is significant. In sum, by virtue of their different types of influence, the identified non-governmental policy actors have the ability to contribute to policy learning at all levels by challenging deep core beliefs and secondary beliefs that influence policy (Jenkins & Sabatier, 1986) at individual levels of governance, or at individual policy sectors.

Identified Policy Documents

Following the identification and mapping of designated multi-level policy actors for examination, I turned to identifying policy documents produced by each of these policy actors which inform the policy subsystem of MHSUD. Methods for identifying documents, discussion

of the types of documents included, and a complete list of identified documents are examined below. Given this inclusion criteria, 165 documents were identified for examination. Table 5.3 has the documents listed by policy stakeholder and by date of publication. In addition, colour-coding from Table 5.1 above is continued here so that for each stakeholder, there is also an identification of whether the documents produced have legislative, service-provisional or advocacy-related power.

Table 5.3 Policy Documents Identified for Examination (*Organized by Policy Sector and Date)*

Level of Governance	Policy Sector	Policy Actor	Policy Document	Type of Document	Document Code	Link
Federal	**Health**	**Public Health Agency of Canada**	An evaluation guide to support community-based interventions to prevent substance-related harms in youth (2022)	Position Paper	F1	https://www.canada.ca/en/public-health/services/publications/healthy-living/guide-support-community-based-interventions-prevent-substance-related-harms-youth.html
			Preventing substance-related harms among Canadian youth through action within school communities: A policy paper (2021a)	Position Paper	F2	https://www.canada.ca/en/public-health/services/publications/healthy-living/policy-paper-preventing-substance-related-harms-canadian-youth-action-school-communities.html
			Blueprint for action: preventing substance-related harms among youth through a comprehensive school health approach (2021b)	Position Paper	F3	https://www.canada.ca/en/public-health/services/publications/healthy-living/blueprint-for-action-preventing-substance-related-harms-youth-comprehensive-school-health/guide.html
			Beyond Health Education: Preventing Problematic Substance Use by Enhancing Student WellBeing (2019a)	Position Paper	F4	https://publications.gc.ca/collections/collection_2019/aspc-phac/HP10-29-2019-eng.pdf
			Promoting Wellbeing; Supporting Students' Wellbeing Can Reduce Risk of Problematic Substance Use (2019b)	Position Paper	F5	https://publications.gc.ca/collections/collection_2019/aspc-phac/HP10-28-2019-eng.pdf
			Welcoming Environments: School Communities Help to Prevent Problematic Substance use (2019c)	Position Paper	F6	https://publications.gc.ca/collections/collection_2019/aspc-phac/HP10-27-2019-eng.pdf
			Effective Programming: Effective Universal School-based Programs (2019d)	Position Paper	F7	https://publications.gc.ca/site/eng/9.869825/publication.html
		Chief Public Health Officer of Canada	Preventing Problematic Substance Use in Youth (2018)	Position Paper	F8	https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/2018-preventing-problematic-substance-use-youth.html
		Health Canada	Health Canada Announces Nearly $10 Million to Support Indigenous Communities Across Canada to Address Substance Related Harms (2022)	News Release	F9	https://www.canada.ca/en/health-canada/news/2022/12/health-canada-announces-nearly-10-million-to-support-indigenous-communities-across-canada-to-address-substance-related-harms.html
			What We Heard: Strengthening Approaches to Substance Use Issues (2019)	Position Paper	F10	https://www.canada.ca/en/health-canada/services/publications/healthy-living/what-we-heard-strengthening-approach-substance-use-issues.html
			Strengthening Canada's Approach to Substance Use Issues (2018)	Position Paper	F11	https://www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy/strengthening-canada-approach-substance-use-issue.html
			Canada Health Act (2017)	Federal Legislation	F12	https://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html
			Canadian Drugs and Substances Strategy (2016a)	Horizontal Federal Initiative	F13	https://www.canada.ca/en/health-canada/corporate/transparency/corporate-management-reporting/report-plans-priorities/2018-2019-supplemental-information-tables.html#a4a
			Interim Report and Recommendations on the Opioid Crisis in Canada (2016b)	Outcome Report	F14	https://publications.gc.ca/site/eng/9.827826/publication.html
			National Native Alcohol and Drug Abuse Program Treatment Center Outcome Study (2012)	Outcome Report	F15	https://publications.gc.ca/site/eng/9.853430/publication.html

	Indigenous Services Canada	**Indigenous Health**	Jordan's Principle (2023)	Website	F16	https://www.sac-isc.gc.ca/eng/1568396042341/1568396159824
			National Youth Solvent Abuse Program (2019)	Outcome Report	F17	https://www.sac-isc.gc.ca/eng/1576090099314/1576090141721
	National Indigenous Leadership	**Assembly of First Nations**	Accessing Jordan's Principle (2021)	Position Paper	F18	https://www.afn.ca/wp-content/uploads/2021/07/Sector-Update-Jordans-Principle-June-2021-EN.pdf
			Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues (2011)	Position Paper	F19	https://thunderbirdpf.org/wp-content/uploads/2022/04/honouring_our_strengths.pdf
	Federal Cross-Sector Initiatives	**Public Safety Canada**	Substance Use Prevention Projects: British Columbia (2015a)	Program summary	F20	https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/sbstnc-bs-prvntn-bc/index-en.aspx
			Substance Use Prevention Projects: Prairies (2015b)	Program summary	F21	https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/sbstnc-bs-prvntn-prrs/index-en.aspx
			Final Program Evaluation: Towards No Drug Abuse (2015c)	Program summary	F22	https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/2015-r010/2015-r010-en.pdf
			Promising Practices in Policing Substance Users (2012)	Program summary	F23	https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/prmsng-prctcs-plcng/prmsng-prctcs-plcng-eng.pdf
			Family-Adolescent Straight Talk (FAST) (2011)	Program summary	F24	https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/dy-sspnsn-prgrm/dy-sspnsn-prgrm-eng.pdf
		Canadian Center on Substance Abuse	Understanding Substance Use: Educator's Guide (2022)	Guideline Document	F25	https://www.ccsa.ca/sites/default/files/2022-09/Understanding-Substance-Use-Educators-Guide-en.pdf
			Rapid Access Models for Substance Use Services (2020)	Service Delivery Framework	F26	https://www.ccsa.ca/sites/default/files/2020-10/CCSA-Rapid-Access-Models-Substance-Use-Services-Rapid-Review-Report-2020-en.pdf
			Moving to a Recovery-Oriented System of Care (2017)	Position Paper	F27	https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Recovery-Oriented-System-of-Care-Resource-2017-en.pdf
			Awareness to Recovery Pathway for Treatment of Youth (2016a)	Position Paper	F28	https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Care-Pathways-Youth-Prescription-Drug-Treatment-Online-2016-en.pdf
			Universal Family-Based Substance Abuse Prevention for Youth (2016b)	Position Paper	F29	https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Universal-Family-based-Prevention-Youth-Rapid-Review-2014-en.pdf
			Addiction and Mental Health Care: Resources to Support Collaboration (2016c)	Position Paper	F30	https://www.ccsa.ca/sites/default/files/2019-05/CCSA-Addiction-Mental-Health-Collaborations-Summary-2016-en.pdf
			Collaboration for Addiction and Mental Health Care: Best Advice (2015)	Position Paper	F31	https://www.ccsa.ca/collaboration-addiction-and-mental-health-care-best-advice-report
			Canadian Center on Substance Abuse Act (Government of Canada, 2012)	Federal Legislation	F32	https://laws-lois.justice.gc.ca/eng/acts/C-13.4/FullText.html
			Services and Supports for Youth Substance Use Treatments (2012)	Service Delivery Framework	F33	https://www.ccsa.ca/sites/default/files/2019-05/CCSA-Youth-Drug-Treatment-Summary-2012-en.pdf
		Joint Consortium on School Health	Pan-Canadian Joint Consortium on School Health (2023)	Website	F34	http://www.jcsh-cces.ca/en/about-us/
Provincial – Manitoba	**Mental Health and Community Wellness**	**Mental Health and Community Wellness**	Youth Addiction Agencies (Retrieved 2023a)	Website	PM1	http://mbaddictionhelp.ca/services/addiction-services-for-youth/
			Province Expands Strongest Families Institute Program (Retrieved 2023b)	News Release	PM2	https://news.gov.mb.ca/news/index.html?item=53099

			A Pathway to Mental Health and Community Wellness: A Roadmap for Manitoba (2022a)	Guideline Document	PM3	https://www.gov.mb.ca/mh/docs/roadmap.pdf
			Manitoba Government Commits to Recovery-Oriented System of Addictions Care (2022b)	Press Release	PM4	https://news.gov.mb.ca/news/index.html?item=56861&posted=2022-11-09
			Manitoba Government Invests $625000 in Initiatives to Combat Addictions (2022c)	Press Release	PM5	https://news.gov.mb.ca/news/index.html?item=56762&posted=2022-11-01
			Manitoba Government and United Way Launch Mental Health and Addiction Services Youth Hubs (2022d)	News Release	PM6	https://news.gov.mb.ca/news/index.html?item=54354&posted=2022-05-04
	Health	**Manitoba Health, Healthy Living and Seniors**	Health System Transformation (Retrieved 2023)	Website	PM7	https://gov.mb.ca/health/hst/program.html
			Mental Health Act (2022a)	Legislation	PM8	https://web2.gov.mb.ca/laws/statutes/ccsm/_pdf.php?cap=m110
			Bill 10: Regional Health Authorities Amendment Act (2022b)	Legislation	PM9	https://www.gov.mb.ca/health/hst/docs/bill10_technical_briefing_spring2021.pdf
			Health System Governance Accountability Act (2022c)	Legislation	PM10	https://web2.gov.mb.ca/bills/41-4/b010e.php
			The Public Health Act (2022d)	Legislation	PM11	https://www.gov.mb.ca/health/publichealth/act.html
			Harm Reduction Position Statement (Chief Provincial Public Health Officer, 2016)	Position Statement	PM12	https://www.gov.mb.ca/health/cppho/docs/ps/harm_reduction.pdf
		Virgo Planning	Improving Access and Coordination of Mental Health and Addictions Services (2018)	Strategic Plan	PM13	https://www.gov.mb.ca/mhcw/about/reports/virgo.html
		Addictions Foundation of Manitoba	Programs and Services for Youth (Retrieved 2023)	Website	PM14	https://afm.mb.ca/programs-and-services/for-youth/
	Education	**Ministry of Education and Early Childhood Learning**	Standards for Appropriate Educational Programming in Manitoba (2022a)	Standards Manual	PM15	https://www.edu.gov.mb.ca/k12/specedu/aep/pdf/standards_for_student_services.pdf
			Education Administration Act (2022b)	Legislation	PM16	https://web2.gov.mb.ca/laws/statutes/ccsm/_pdf.php?cap=e10
			Public Schools Act (2022c)	Legislation	PM17	https://web2.gov.mb.ca/laws/statutes/ccsm/_pdf.php?cap=p250
			Safe and Caring Schools: Planning for Safety and Belonging (2017a)	Guideline document	PM18	https://www.edu.gov.mb.ca/k12/docs/support/whole_school/document.pdf
			Provincial Code of Conduct (2017b)	Ministerial Directive	PM19	https://www.edu.gov.mb.ca/k12/safe_schools/pdf/code_conduct.pdf
			Appropriate Educational Programming Regulation (2006)	Legislative Regulation	PM20	https://web2.gov.mb.ca/laws/regs/current/_pdf-regs.php?reg=155/2005
	Child and Family Services	**Ministry of Families**	Youth Drug Stabilization Act (2023a)	Legislation	PM21	https://web2.gov.mb.ca/laws/statutes/ccsm/y050.php
			Child and Family Services Act (2023b)	Legislation	PM22	https://web2.gov.mb.ca/laws/statutes/ccsm/_pdf.php?cap=c80
			Child and Family Services Standards Manual (2022c)	Policy Manual	PM23	https://www.gov.mb.ca/fs/cfsmanual/index.html
	Cross-Sector Partnerships	**Manitoba Healthy Schools**	Manitoba Healthy Schools Initiative (2023)	Website	PM24	https://www.gov.mb.ca/healthyschools/index.html
		Government of Manitoba	Province Invests $4.4 Million to Enhance Mental Wellness in Schools (2019)	Press Release	PM25	https://news.gov.mb.ca/news/index.html?item=46417&posted=2019-12-02
Provincial-British Columbia	**Mental Health**	**Ministry of Mental Health and Addictions**	Mental Health Act (2023a)	Legislation	PBC1	https://www.bclaws.gov.bc.ca/civix/content/complete/statreg/13255249 18/96288/?xsl=/templates/browse.xsl
			Mental Health and Substance Use Supports (2023b)	Website	PBC2	https://www2.gov.bc.ca/gov/content/mental-health-support-in-bc/addictions-alcohol-and-other-substances
			Indigenous Child and Mental Health Services (2023c)	Website	PBC3	https://www2.gov.bc.ca/gov/content/health/managing-your-health/mental-health-substance-use/child-teen-mental-health/indigenous-child-teen-mental-health

			Pathway to Hope Update (2021)	Strategic Plan Update	PBC4	https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/mental-health-addictions/pathway_to_hope_update_report_final.pdf
			Pathway to Hope (2019)	Strategic Plan	PBC5	https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/initiatives-plans-strategies/mental-health-and-addictions-strategy/bcmentalhealthroadmap_2019web-5.pdf
	Health	**Ministry of Health**	Public Health Act (2023)	Legislation	PBC6	https://www.bclaws.gov.bc.ca/civix/content/complete/statreg/1922970521/08028/?xsl=/templates/browse.xsl
			Ministry of Health Act (2023)	Legislation	PBC7	https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96301_01
			Organizations Supporting Mental Health and Substance Use in BC (2023)	Website	PBC8	https://www2.gov.bc.ca/gov/content/health/managing-your-health/mental-health-substance-use/organizations
			Ministry of Health Service Plan (2022)	Strategic Plan	PBC9	https://www.bcbudget.gov.bc.ca/2022/sp/pdf/ministry/hlth.pdf
			Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness (2018)	Guideline Document	PBC10	https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/health/office-of-indigenous-health/mou-mental-health-wellness-sdoh-2018.pdf
			Improving Health Services for Individuals with Severe Addiction and Mental Illness (2013)	Strategic Plan	PBC11	https://www.health.gov.bc.ca/library/publications/year/2013/improving-severe-addiction-and-mental-illness-services.pdf
	Education	**Ministry of Education and Childcare**	School Act (2023)	Legislation	PBC12	https://www.bclaws.gov.bc.ca/civix/content/complete/statreg/1527898742/96412/?xsl=/templates/browse.xsl
			Mental Health in Schools Strategy (2020)	Guideline Document	PBC13	https://www2.gov.bc.ca/assets/gov/erase/documents/mental-health-wellness/mhis-strategy.pdf
			Provincial Standards for Codes of Conduct Order (2016)	Ministerial Directive	PBC14	https://www2.gov.bc.ca/assets/gov/education/administration/legislation-policy/legislation/schoollaw/e/m276_07.pdf
	Child Welfare	**Child and Family Develop-ment**	Child, Family and Community Services Act (2023)	Legislation	PBC15	https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96046_01#part1
			Child and Youth Mental Health Services (2023)	Website	PBC16	https://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/child-teen-mental-health/child_and_youth_mental_health_tool_kit.pdf
			Child and Youth Mental Health Service Framework (2019)	Guideline Document	PBC17	https://www2.gov.bc.ca/assets/gov/health/child-teen-mental-health/cymh_service_framework_2019-20.pdf
			Aboriginal Policy and Practice Framework in British Columbia (2015)	Guideline Document	PBC18	https://www2.gov.bc.ca/assets/gov/family-and-social-supports/indigenous-cfd/abframework.pdf
			Families at the Center: A Planning Framework for Public Systems in BC (2015)	Guideline Document	PBC19	https://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/child-teen-mental-health/families_at_the_centre_summary.pdf
	Cross-Sector Partnerships	**Healthy Minds, Healthy People**	Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (2010)	Strategic Plan	PBC20	https://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf
		Select Standing Committee on Children and Youth	Concrete Actions for Systemic Change: Final Report Child and Youth Mental Health in British Columbia	Report	PBC21	https://www.leg.bc.ca/content/CommitteeDocuments/40th-parliament/4th-session/cay/reports/PDF/Report_SSC-CY-40-4-3_Concrete-Actions-For_Systemic_Change.pdf
Provincial - Indigenous	**Indigenous Governance**	**Assembly of Manitoba Chiefs**	The Implementation of Jordan's principle in Manitoba: Final Report (2022)	Report	PI1	https://manitobachiefs.com/wp-content/uploads/22-01-28-The-Implementation-of-Jordans-Principle-in-Manitoba-Final-Report.pdf

		BC Assembly of First Nations	Centering First Nations Concepts of Wellbeing (2020)	Report	PI2	https://www.bcafn.ca/sites/default/files/docs/reports-presentations/BC%20AFN%20FINAL%20PRINT%202020-11-23.pdf
Regional - Winnipeg	**Identified Regional Health Authorities**	**Winnipeg Regional Health Authority**	Winnipeg Regional Health Authority: Mental Health (accessed Jan29, 2023)	website	RM1	https://wrha.mb.ca/mental-health/
			Winnipeg Regional Health Authority: Strategic Plan 2023-2028 (2022)	Strategic Plan	RM2	https://wrha.mb.ca/files/strategic-plan-2023-2028.pdf
			WRHA Community Assessment (2019)	Community Report	RM3	https://wrha.mb.ca/files/cha-2019-full-report.pdf
			WRHA Community Assessment (2014)	Community Report	RM4	https://wrha.mb.ca/files/cha-2014-full-report.pdf
		Shared Health	Mental Health and Addictions: Shared Health (2023)	website	RM5	https://sharedhealthmb.ca/services/mental-health/matc/
			Healing Our System (2019a)	Strategic Plan	RM6	https://sharedhealthmb.ca/wp-content/uploads/CPSP_Overview_NL.pdf
			Healing Our System Audit Report (2019b)	Community Report	RM7	https://sharedhealthmb.ca/files/phase-two-report.pdf
		Winnipeg School Division	Inclusive Education Services (2023a)	website	RM8	https://www.winnipegsd.ca/page/9566
			Jordan's Principle WSD Partnership (2023b)	website	RM9	https://scoinc.mb.ca/sco-wsd-partnership/
			Student Search and Seizure (2020)	Policy Document	RM10	https://sbwsdstor.blob.core.windows.net/media/Default/medialib/jfg-student-search-and-seizure.009e3913012.pdf
			Restorative Practice Policy (2022)	Policy Document	RM11	https://sbwsdstor.blob.core.windows.net/media/Default/medialib/jgdd-restorative-practice.8ef4e121932.pdf
			Safe Schools Policy (2019)	Policy Document	RM12	https://sbwsdstor.blob.core.windows.net/media/Default/medialib/jg-safe-schools.1226a313015.pdf
	Identified CFS Authority	**Southern First Nations Network**	Southern First Nations Network (Accessed 2023)	website	RM13	https://www.southernnetwork.org/site/agency-west-region-child-family-services
Regional-Vancouver	**Regional Health Authority**	**Coastal Health Authority**	Vancouver Coastal Authority (Accessed 2023)	website	RBC1	http://www.vch.ca/public-health/children-youth-schools/youth-health/youth-addiction
			Vancouver Coastal Authority Strategic Plan 2021-23 (2021)	Strategic Plan	RBC2	https://www.vch.ca/en/about-us/strategic-priorities
		First Nations Health Authority	First Nations Health Authority: Mental Wellness and Substance Use (2023)	Website	RBC3	https://www.fnha.ca/what-we-do/mental-wellness-and-substance-use/mental-health-and-wellness-supports
			First Nations Health Authority: Service Plan (2021)	Service Plan	RBC4	https://www.fnha.ca/about/governance-and-accountability/summary-service-plan
		Provincial Health Authority	Provincial Health Authority: Mental Wellness and Substance Use (2023)	Website	RBC5	http://www.bcmhsus.ca
	Identified School Division	**Vancouver School Board**	Student Support (2023a)	website	RBC6	https://www.vsb.bc.ca/page/5151/mental-health
			Substance Abuse Health Promotion Initiative (2023b)	website	RBC7	https://www.vsb.bc.ca/page/5152/sacy-substance-use-health-promotion-initiative
			Vancouver School Board Administrative Procedures Manual (Retrieved 2023c)	Policy Document	RBC8	https://www.vsb.bc.ca/page/4850
NGOs/ Advocacy Groups	**Identified National NGO**	**Mental Health Commission of Canada**	The Time is Now: Considerations of a National Psychotherapy Program (2022)	Report	NGO1	https://mentalhealthcommission.ca/resource/the-time-is-now-considerations-for-a-national-psychotherapy-program/
			Stepped Care 2.0 (2021)	Report	NGO2	https://mentalhealthcommission.ca/wp-content/uploads/2021/11/What-is-Stepped-Care-2.0-4-pager.pdf

			Combatting Mental Illness and Substance Use Related Structural Stigma in Health Care – A Framework for Action (2020)	Report	NGO3	https://mentalhealthcommission.ca/resource/combating-mental-illness-and-substance-use-related-structural-stigma-in-health-care-a-framework-for-action-2/
			Strengthening the Case for Investing in Canada's Mental Health System (2018)	Report	NGO4	https://mentalhealthcommission.ca/resource/strengthening-the-case-for-investing-backgrounder/
			Funding Expanded Access to Psychological Interventions (2017)	Report	NGO5	https://mentalhealthcommission.ca/resource/funding-expanded-access-to-psychological-interventions/
			Substance Use and Suicide Among Youth: Preventions and Interventions Strategies (2017)	Report	NGO6	https://mentalhealthcommission.ca/resource/substance-use-and-suicide-among-youth-prevention-and-intervention-strategies/
			School-Based Mental Health in Canadian Schools (2013)	Report	NGO7	https://mentalhealthcommission.ca/resource/school-based-mental-health-in-canada-a-final-report/
Media	**CBC News 2013-2023**	**Manitoba**	Manitoba Falling Behind in Mental Health Care (24 May, 2022)	Media Report	MM1	https://www.cbc.ca/news/canada/manitoba/manitoba-falling-behind-in-mental-health-care-due-to-inadequate-funding-1.6461721
			The Manitoba Government's Mental Health Strategy (17 February, 2022)	Media Report	MM2	https://www.cbc.ca/news/canada/manitoba/manitoba-government-mental-health-strategy-1.6355782
			Substance Use, Mental Health Top Lists of Concerns for Youth (19 Aug, 2021)	Media Report	MM3	https://www.cbc.ca/news/canada/manitoba/manitoba-children-s-advocate-youth-listening-tour-report-1.6146123
			Manitoba slow to implement new mental health supports for children and youth: Advocate (Nov 17, 2020)	Media Report	MM4	https://www.cbc.ca/news/canada/manitoba/manitoba-childrens-advocate-report-1.5805855
			Youth with mental illnesses should have access to long-term in-patient care (Feb 27, 2020)	Media Report	MM5	https://www.cbc.ca/news/canada/manitoba/macy-youth-suicide-report-1.5477679
			Manitoba earmarks $4.2 million to boost youth mental health services (Nov 18, 2019)	Media Report	MM6	https://www.cbc.ca/news/canada/manitoba/manitoba-youth-mental-health-funding-1.5363589
			Mental Health treatment for Indigenous youth must draw on tradition. March 30, 2019	Media Report	MM7	https://www.cbc.ca/news/canada/manitoba/manitoba-virgo-report-indigenous-health-tina-fontaine-1.5077015
			Extending involuntary confinement for at-risk youth a last resort, but sometimes necessary: child advocate March 14, 2019	Media Report	MM8	https://www.cbc.ca/news/canada/manitoba/child-advocate-recommendation-sexually-exploited-youth-1.5055437
			Gap in addictions, mental health services placing kids in care at risk Jan 16, 2019	Media Report	MM9	https://www.cbc.ca/news/canada/manitoba/manitoba-childrens-advocate-committee-meeting-1.4981086
			Lock up Chronic Runaways to Keep them Safe: Winnipeg Police Officer	Media Report	MM10	https://www.cbc.ca/news/canada/manitoba/lock-up-chronic-runaways-to-keep-them-safe-winnipeg-police-officer-1.2783146
			Child Advocate Blasts Manitoba's mental health, addiction supports (21 Sept, 2018)	Media Report	MM11	https://www.cbc.ca/news/canada/manitoba/daphne-penrose-child-mental-health-1.4833766
			Youth addiction treatment center cutting 4 staff positions (Sept 13, 2018)	Media Report	MM12	https://www.cbc.ca/news/canada/manitoba/additions-youth-treatment-centre-1.4821499
			Study suggests strong relationship between bullying and drug use (Mar 11, 2018)	Media Report	MM13	https://www.cbc.ca/news/canada/manitoba/study-bullying-drugs-1.4564397
			Drop in Program offers meth-addicted youth a chance to get clean (July 25, 2018)	Media Report	MM14	https://www.cbc.ca/news/canada/manitoba/meth-support-winnipeg-13-moons-1.4759882
			Take action to combat rising number of youth using meth: Children's Advocate (October 25, 2017)	Media Report	MM15	https://www.cbc.ca/news/canada/manitoba/crystal-meth-addiction-youth-manitoba-children-s-advocate-1.4372228

			Treatment centers for youth battling addiction at risk of closing (May 19, 2016)	Media Report	MM16	https://www.cbc.ca/news/canada/manitoba/treatment-centre-youth-addiction-manitoba-indigenous-cultural-teachings-1.3590465
			Try everything to stop kids/drug abuse, youth worker tells parents (Feb 24, 2016)	Media Report	MM17	https://www.cbc.ca/news/canada/manitoba/parents-kids-drug-abuse-1.3461747
			Manitoba lacks services for at-risk youth (Sept 2, 2014)	Media Report	MM18	https://www.cbc.ca/news/canada/manitoba/former-gang-member-raising-awareness-to-help-at-risk-youth-1.2753605
			Former student tells school trustees more needs to be done to curb addiction (May 9, 2017)	Media Report	MM19	https://www.cbc.ca/news/canada/manitoba/addictions-drugs-alcohol-in-school-1.4105887
			Parents of children with meth addiction feel left out of illicit drugs report (June 28, 2019)	Media Report	MM20	https://www.cbc.ca/news/canada/manitoba/mothers-react-meth-task-force-report-1.5194776
		British Columbia	Indigenous Advocates Call for More Culturally Informed Addictions Treatment (February 13, 2023)	Media Report	MBC1	https://www.cbc.ca/news/indigenous/drug-crisis-addictions-culture-1.6744188
			Closure of Vancouver youth detox program "devastating" (April 1, 2022)	Media Report	MBC2	https://www.cbc.ca/news/canada/british-columbia/youth-detox-vancouver-closure-1.6404873
			Last door recovery society marks 25 years of helping youth (June 8, 2021)	Media Report	MBC3	https://www.cbc.ca/news/canada/british-columbia/last-door-recovery-25-anniversary-1.6057202
			Vancouver model of drug decriminalization deeply flawed, national coalition says May 12, 2021	Media Report	MBC4	https://www.cbc.ca/news/canada/british-columbia/vancouver-decriminalization-model-flawed-national-coalition-says-1.6022310
			BC children's advocate says youth with mental illness retraumatized by involuntary admissions (Jan 19, 2021)	Media Report	MBC5	https://www.cbc.ca/news/canada/british-columbia/bc-children-youth-representative-report-involuntary-detention-overdose-1.5879063
			Province hits pause on controversial bill that would allow involuntary hospitalization of youth (July 27, 2020)	Media Report	MBC6	https://www.cbc.ca/news/canada/british-columbia/bill-22-bc-mental-heatlh-act-1.5663935
			"Beautiful boy" slipped between health care cracks, father says, after BC inquest (June 27, 2019)	Media Report	MBC7	https://www.cbc.ca/news/canada/british-columbia/youth-overdose-inquest-1.5191686
			Cannabis in the Classroom: Educators Prepare for Legalization (Oct. 8, 2018)	Media Report	MBC8	https://www.cbc.ca/news/canada/british-columbia/cannabis-in-the-classroom-educators-prepare-for-legalization-1.4855534
			This is what an overdose looks Like: Schools the New Front Line of Fentanyl Awareness (September 5, 2017)	Media Report	MBC9	https://www.cbc.ca/news/health/overdose-education-schools-1.4260426
			Iceland is Beating Teenage Substance Use – Could BC Follow Suit? (February 3, 2017)	Media Report	MBC10	https://www.cbc.ca/news/canada/british-columbia/iceland-teenage-substance-abuse-1.3962146
			Drug Education in BC Schools Changing to Reflect Overdose Crisis (May 31, 2017)	Media Report	MBC11	https://www.cbc.ca/news/canada/british-columbia/overdose-education-b-c-1.4140718
			Anyone can be affected by substance use: New West youth addiction center celebrates 20 years (March 24, 2016)	Media Report	MBC12	https://www.cbc.ca/news/canada/british-columbia/last-door-youth-addiction-program-in-new-westminster-celebrates-20-years-1.3505643
			Youth using marijuana daily are at risk of addiction, psychosis (Feb 12, 2016)	Media Report	MBC13	https://www.cbc.ca/news/canada/british-columbia/marijuana-youth-1.3446246
			Vancouver psychiatrist calls out lack of treatment options for at-risk youth (October 25, 2016)	Media Report	MBC14	https://www.cbc.ca/news/canada/british-columbia/vancouver-psychiatrist-limited-services-for-youth-1.3820948
Target Groups	**Advocate Reports**	**Manitoba Advocate for Children and Youth**	Rights Delayed are Rights Denied (2022)	Summary Report	MACY1	https://manitobaadvocate.ca/wp-content/uploads/MACY-Compliance-Report-2022-Final-Print.pdf
			Finding the Way Back (2021)	Special Report	MACY2	https://manitobaadvocate.ca/wp-content/uploads/MACY-Special-Report-Finding-the-Way-Back.pdf
			The Right to Be Heard (2021)	Special Report	MACY3	https://manitobaadvocate.ca/wp-content/uploads/MACY-Mini-Youth-Report-Listening-TourSCREEN-Spreads-FIN.pdf

			Kids Can't Keep Waiting (2021)	Summary Report	MACY4	https://manitobaadvocate.ca/adult/reports-publications/special-reports/
			Still Waiting: Investigating Child Maltreatment After the Phoenix Sinclair Inquiry (2021)	Special Report	MACY5	https://manitobaadvocate.ca/wp-content/uploads/Maltreatment_Report.pdf
			Are They Listening (2020)	Summary Report	MACY6	https://manitobaadvocate.ca/wp-content/uploads/Are-They-Listening.pdf
			Stop Giving Me a Number and Start Giving Me a Person (2020)	Special Report	MACY7	https://manitobaadvocate.ca/wp-content/uploads/MACY-Special-Report-Suicide-Aggregate-2020.pdf
			The Slow Disappearance of Matthew (2020)	Special Report	MACY8	https://www.google.com/search?client=safari&rls=en&q=slow disappearance+of+matthew&ie=UTF-8&oe=UTF-8
			A Place Where it Feels Like Home: The Story of Tina Fontaine (2019)	Special Report	MACY9	https://manitobaadvocate.ca/wp-content/uploads/2019/07/Tina-Fontaine.pdf
			In Need of Protection: Angel's Story (2018)	Special Report	MACY10	https://manitobaadvocate.ca/wp-content/uploads/2019/05/Angels-Story.pdf
			Documenting the Decline: The Dangerous Space Between Good Intentions and Meaningful Interventions	Special Report	MACY11	https://manitobaadvocate.ca/wp-content/uploads/2019/05/Documenting-Decline.pdf
		British Columbia Representative for Children and Youth	A Parent's Responsibility: Government's Obligation to Improve Mental Health Outcomes of Children in Care (2022)	Special Report	RCY1	https://rcybc.ca/wp-content/uploads/2022/09/RCY-ParentsResponsibility-Sept2002.pdf
			Detained: Rights of Children and Youth Under the Mental Health Act (2021)	Special Report	RCY2	https://rcybc.ca/wp-content/uploads/2021/01/RCY_Detained-Jan2021.FINAL_.pdf
			From Marginalized to Magnified: Youth Homelessness Solutions from Those with Lived Experiences (2020)	Special Report	RCY3	https://rcybc.ca/wp-content/uploads/2020/02/Final.From-Marginalized-to-Magnified.pdf
			Time to Listen: Youth Voices on Substance Use (2018)	Special Report	RCY4	https://rcybc.ca/wp-content/uploads/2019/04/timetolisten-youthvoicesonsubstanceuse-2018-web-final.pdf
			Caught in the Middle (2019)	Special Report	RCY5	https://rcybc.ca/wp-content/uploads/2019/12/rcy-caught-in-the-middle_nov2019-webversion.pdf
			Missing Pieces: Joshua's Story (2017)	Special Report	RCY6	https://rcybc.ca/wp-content/uploads/2020/01/rcy-missingpieces-joshuasstory_report_oct_4.pdf
			Broken Promises: Alex's Story (2017)	Special Report	RCY7	https://rcybc.ca/wp-content/uploads/2019/04/rcy-brokenpromises-alexsstory-feb2017-lo_web-2.pdf
			Review of substance use services in BC (2016)	Special Report	RCY8	https://rcybc.ca/wp-content/uploads/2019/04/rcy_reviewyouthsubstance-final.pdf
			Last Resort: One Family's Tragic Struggle to Find Help for Their Son (2016)	Special Report	RCY9	https://rcybc.ca/wp-content/uploads/2019/04/rcy-lastresort-oct2016_final.pdf
			Paige's Story: Abuse, Indifference and a Young Life Discarded (2015)	Special Report	RCY10	https://rcybc.ca/wp-content/uploads/2019/05/rcy-pg-report-final.pdf

Key Takeaways: Stakeholder Mapping and Document Identification

I identified 37 stakeholders in the multi-level policy subsystems of youth MHSUD responses in Manitoba and British Columbia and 165 corresponding documents for analysis. Legislative responses, service provision responses, and advocacy-based responses were all present in the identified policy stakeholder documents which included legislation, reports, policies, strategic plans, press releases, stakeholder websites, media articles, and position papers. Single-sector policy responses were most common, but cross-sector responses were still noted at the federal, provincial, and regional levels

Emerging Themes on Stakeholder Policy Discourses for Governmental Stakeholders

Following identification of stakeholders and policy documents for examination in the policy area of youth MHSUD in both Manitoba and British Columbia, I identified and analyzed the documented multi-level policy actions and reactions of these stakeholders. As discussed in the Methodology section, I continued the Stakeholder Analysis with collection of signifiers for the following discourses (in keeping with Weible (2006):

1) Discourses of intent (as a measure of policy interests and beliefs): What discourses identify stakeholders' policy interests and beliefs about MHSUD?
2) Discourses of action: What discourses are used to describe resources, strategies and venues are being leveraged? Who controls these resources? At what level? Are they symbolic or material?
3) Discourses of coordination: What discourses are used to describe existing coalitions and coordination already demonstrated in the document? Vertical or horizontal? What are

identified opportunities for and barriers to coordination at the policy and/or service provision level?

In total, nine distinct discourses of intent were identified in documents based on their purpose. Each theme is colour-coded below. The discourses of intent for governmental documents included intents in a policy response to:

1) Promote **cross-sector, socio-ecological responses to MHSUD** with intent to minimize harms—where policy interests were rooted in multi-sector approaches to planning for MHSUD responses with acknowledgement that harms associated with MHSUD span health, social, economic, educational contexts;
2) Promote **bio-medical health/public health responses to MHSUD**—where policy interests were rooted in attempts to treat MHSUD with single-sector health modalities of diagnosis and treatment;
3) Promote **social responses to MHSUD**—where policy interests were rooted in single-sector social responses;
4) Administer **service provision for MHSUD**—where policy interests were tied to provision direct service for MHSUD;
5) Promote **primary prevention programming for MHSUD**—where policy interests were to provide prevention and educational programming for MHSUD;
6) Respond to **MHSUD as a public safety issue**—where policy interests showed efforts to treat MHSUD as a potential threat to public safety;
7) Administrate and maintain of **safe schools**—where policy interests were to ensure that MHSUD issues in schools did not compromise student or staff safety;

8) **Implement appropriate educational programming**—where policy interests were to provide school supports to students which could include mental health supports; and
9) **Assess existing resources for MHSUD**—where policy documents completed audits to review current policy frameworks in order to plan strategic directions.

Following coding for the discourses of intent (as a measure of policy interests) of the policy documents themselves, I used CDA to identify signifiers that identified discourses used to represent primary beliefs about MHSUD as a policy problem. This secondary analysis of discourses allowed me to compare how conceptions of MHSUD as a policy problem—and the beliefs that underscore that policy problem—informed articulated policy intents. This allowed for an analysis of whether discourses of MHSUD used to validate policy actions are aligned with both secondary beliefs (interests) and primary beliefs, thus, discourses of intent. Throughout the documentation, seven discourses of primary beliefs were used to discuss MHSUD as a policy problem, including:

1) **MHSUD as a socio-ecological health issue**—where MHSUD predisposes individuals to a variety of social, health, familial, educational and wellbeing harms;
2) **MHSUD as a public health/biomedical health issue**—as supported by single-sector treatment and participation in a diagnosis-treatment-recovery paradigm;
3) **MHSUD as a moral/justice issue**—where MHSUD is rooted in discussions of choice;
4) **MHSUD as a safety issue**—where MHSUD is a danger to public safety or school safety;
5) **MHSUD as a reconciliation issue—**framing MHSUD as a symptom of colonialism;
6) **MHSUD as a mental health issue**—where mental health is treated separately from discussions of physical health including discussions of psychological "disorders" where there is a tendency diagnose disorders as internal to the person; and

7) **MHSUD as an educational programming issue**—related to additional student needs.

Following this initial analysis and coding, I looked for signifiers related to discourses of action—that is, what material and symbolic policy actions were undertaken in the name of this policy intents—and discourses of coordination—that is, what coalitions already exist, and what factors exist as barriers or catalysts to ongoing coordination. I began with the federal document data set, then moved on to provincial and regional document data sets.

Federal Documents

In total, 34 federal and cross-Canadian governmental documents were examined. As per the inclusion criteria, these documents represented policy actions from the following stakeholders:

- The Public Health Agency of Canada (PHAC)
- The Chief Public Health Officer of Canada (CPHOC)
- Health Canada (HC)
- Indigenous Services Canada (ISC)
- Assembly of First Nations (AFN)
- Public Safety Canada (PSC)
- The Canadian Center on Substance Abuse (CCSA)
- The Joint Consortium on School Health (JCSH)

Federal Discourses of Intent: What are the stakeholders' interests and beliefs? At the national level, five dominant discourses of intent were identified as framing stakeholder interests in the policy subsystem of MHSUD, including:

(1) treatment of **MHSUD as a cross-sector issue with intent to minimize harms**;

(2) treatment of MHSUD as a **biomedical health issue**;

(3) responding to MHSUD via **provision of services**;

(4) responding to MHSUD by increasing primary **preventative efforts**; and

(5) **ensuring public safety**; and

Reducing economic costs of MHSUD was seen as a secondary discourse in federal documentation. Across the federal documents, MHSUD was characterized as: a socio-ecological health issue, a biomedical health issue, a moral/justice issue, a mental health issue, and a reconciliation issue. These beliefs are discussed in connection to the interests they underscore in the next section. In Table 5.4, I outline dominant discourses of intent, the documents and stakeholder groups which have utilized these discourses, and the conceptualizations of MHSUD which have underscored these discourses.

Table 5.4
Discourses of Intent and Conceptualizations of MHSUD in Federal Documents Examined

Dominant Discourse o Intent *Policy Documents where discourse is used*	**Time-frame Discourse Utilized**	**Stake-holders**	**Examples of Discourses of Interests Supporting the Discourse of Intent**	**Examples of of Discourses of Beliefs Supporting the Discourse of Intent**
Minimize harms from MHSUD by treatment as a cross-sector issue *F1, F2, F3, F10, F11, F19, F25, F26, F30, F31, F34*	*2018-2023*	PHAC HC	• "influence risk and protective factors… modify social surroundings [and] engage community youth" (PHAC, 2022, p. 11) • "decrease range of substance related harms" (PHAC, 2021, p.2) • "Support school stakeholders in engaging… comprehensive approaches" (PHAC, 2021, p. 4) • "decrease harms" (HC, 2019, p. 3) • Participate in the "process of decolonization" (HC, 2011)	**Socio-ecological Health Issue** • "development and behaviours are profoundly shaped by influences that extend far beyond their personal traits and immediate situation. (PHAC, 2022, p. 17) • "substance use and associated harms are shaped by… biological, social, structural and environmental determinants …. beyond an individual's control" (PHAC, 2021, p. 2) • "a complex interplay of factors" (CPHO, 2018, p.1) • "social determinants of health"; underlying social issues lead to a range of harms (HC, 2019, p. 4) • MHSUD "visible and dramatic" symptoms of underlying challenges (AFN, 2011, p. 1) • Links to adverse childhood experiences, trauma, mental health (CCSA 2022, p. 9) • Health and wellbeing outcomes" (PCJCSH 2023, p. 1) • MHSUD "cross-sector issue" requiring collaboration between sectors (CCSA2016) **Biomedical Health Issue** • A health condition that can be managed and treated (HC, 2018, p; p. 14) • Rooted in "addiction service…prevention and treatment" (AFN, 2011, p.1) • SUD a "complete medical condition" (CCSA, 2022, p.8)
Service Provision for MHSUD *F9, F15, F16, F17, F18, F27, F28, F29, F33*	*2012-2022*	HC ISC AFN CCSA	• "Interventions to support Indigenous people (HC, 2022, p. 2) • "help First Nations children living in Canada access the products, services and supports they need (ISC, 2023, p.1)	**Biomedical Health Issue** • "harm reduction… [and] health promotion…[related to] legal and illegal substances" (HC, 2022, p 1) supported by "treatment" in a medical model (HC, 2012, p. 2) • "complex issue that often requires long-term management" (CCSA 2017, p. 4) • "addiction and mental health services...treatment and recovery" (CCSA 2015, p. 1) • "prevention identification, early intervention" (CCSA 2012, p. 2) **Moral/ Justice Issue** • "drug abuse", "addictions" without mention of mental health (IS, 2019, p. 1) **Socio-ecological Health Issue** • reference health, education, criminal justice, social services agencies (CCSA, 2012) • substance us linked to abuse/trauma (CPHO, 2018, p.3)
Primary Prevention *F4, F5, F6, F7, F32*	*2012-2019*	PHAC CCSA	• "Preventing substance use by enhancing wellbeing" (PHAC, 2019a) • "Improving youth protective factors" (PHAC, 2019b)	**Socio-ecological Health Issue** • SUD rooted in "wellbeing" (PHAC 2019a, 2019b, 2019c p. 1) • "strengthen protective factors" (PHAC 2019b, p.1) **Biomedical Health Issue** • MHSUD as linked with health-related harms (CCSA, 2012)
Treatment of MHSUD as a Public Health Issue *F8, F12, F13, F14,*	*2015-2020*	CPHO HC	• "increase life expectancy, improve health" (CPHO, 2018, p. 3) • "public health crisis" (HC, 2019, p. 1) • "using a public health approach" (HC, 2016, p. 4)	**Biomedical Health Issue** • "prevention, harm reduction, treatment and recovery" (CPHO, 2018, p. 3) • "public health approach when …addressing drug issues" (HC, 2016, p. 2) **Mental Health Issue** • Substance use a mental health disorder often comorbid with other MH issues (CPHO, 2018) **An Issue of Colonialism** • "symptom of a colonialism" (CPHO, 2018p. 23)
Ensuring Public Safety *F20-24*	*2011-2015*	PSC	• crime prevention (PSC, 2015, p. 4) • "policing substance users" (PSC, 2012, p. 1)	**Moral/ Justice Issue** • "delinquent behaviour accompanied by substance use" (PSC, 2015, p.1) • "problematize…"risk" (PSC 2015, p.1) in "substance users" (PSC, 2012, p.1)

Themes related to discourses of intent in federal documents. The most common discourse-of-intent in the federal data set was facilitating harm reduction, rooted in a socio-ecological model of health. This discourse was utilized by the Public Health Agency of Canada (PHAC) and Health Canada (HC) in 11 of the examined documents. It was characterized by the intent to reduce social, health, educational, economic, and mental harms caused by MHSUD by employing cross-sector responses to a common issue. For example, calls to "support school stakeholders in engaging their networks, communities and government for increased attention for comprehensive approaches" (PHAC, 2021, p. 4), "influence risk and protective factors… modify social surroundings [and] engage community youth" (PHAC, 2022, p. 11), and participate in the "process of decolonization" (HC, 2011) were coded as cross-sectoral harm-reduction policy intents. Within this discourse-of-intent, MHSUD was characterized as a socio-ecological health issue, acknowledging "substance use and its associated arms are shaped by several biological, social, structural and environmental determinants that are largely beyond an individual's control" (PHAC, 2021, p. 2), but also as a biomedical health issue, simplifying it to a "health condition that can be managed and treated" (HC, 2018, p. 14).

The second most common discourse-of-intent at the federal and cross-national level was an intent to facilitate service provision. This discourse was utilized by HC, the Assembly of First Nations (AFN), the Canadian Center on Substance Use and Addiction (CCSA), and Indigenous Services Canada (ISC) and was present in nine of the examined documents. At the federal level, by virtue of federal control of Indigenous affairs, most documents supporting service provision were aimed at supporting Indigenous populations via "interventions to support Indigenous people (HC, 2022, p. 2) to "help First Nations children living in Canada access the products, services and supports they need" (ISC, 2023, p.1). Within the discourse-of-intent of service

provision, MHSUD was predominantly characterized as a biomedical health issue with clear diagnosis/ treatment duality responses. For example, discussions of "mental health services" (AFN, 2021, p. 2) being offered to support addiction as a "complex [health] issue that often requires long-term management" (CCSA 2017, p. 4). However, it was secondarily framed as a moral/justice-based issue rooted in *choice* to continue with "drug abuse" (IS, 2019). Treatment of mental health as a moral issue was only seen in one other set of documents federally, where MHSUD as a moral issue was a secondary belief to a discourse of belief of public safety.

The third-most utilized discourse of intent in the federal documents was seen in an intent to prevent MHSUD issues. The Public Health Agency of Canada (PHAC) and CCSA utilized this discourse in five of the examined documents. MHSUD within this discourse of belief is characterized as a socio-ecological health issue, with calls to "strengthen protective factors" (PHAC, 2019b, p. 1), but also as a biomedical health issue where "harms" were most often explained only in the case of health-related harms.

The fourth most utilized discourse-of-intent in federal documentation was the discourse of ensuring public safety. This discourse of intent was dominant in five of the examined documents and was supported by discourses of MHSUD as a moral or justice-based issue. Public Safety Canada (PSC) was the only stakeholder using this discourse of intent as a primary discourse. PSC is funded by Justice Canada and is tasked with decreasing "delinquent behaviour accompanied by substance use" (PSC, 2015, p. 1). Only in the public safety intent and in documents responding to Indigenous service provision was MHSUD framed as a moral or justice issue rooted in choice and a cessation of problematic behaviours.

The fifth-most utilized discourse-of-intent in the federal documents examined was that of treatment of MHSUD as a biomedical and public health issue. This discourse was utilized by the

Chief Public Health Officer of Canada (CPHOC) and HC in four examined documents. Signifiers for this discourse included concerns of a "public health crisis" (HC, 2019, p. 1) and a call for "comprehensive, collaborative, compassionate and evidence-based approach to drug policy which uses a public health approach when considering and addressing drug issues (HC, 2016, p. 4). This discourse of intent framed the "drug crisis" as a mental health issue, with goals of increasing health and decreasing health spending. Though there is some acknowledgement of MHSUD as a multi-faceted issue, the documents in this data set tend to be one-dimensional. For example, even when conceding that MHSUD may be a "symptom of a colonialism" (CPHO, 2018, p. 23), it is characterized as a "mental health disorder" (CPHO, 2018, p. 11) without mention of social, economic, historical, or educational factors.

Finally, reducing economic costs of MHSUD was utilized as a discourse in three documents; by the CPHOC, HC and the PHAC. In all three contexts, this secondary discourse was framed one of the "harms" to be considered in broader socio-economic discussions of MHSUD. Signifiers in this discourse of intent included calls to "decrease cost of MHSUD nationally" (CPHOC, 2018, p. 2) and decrease "cost to society" (CCSA, 2020, p. 1).

Varied discourses and changes in discourses over time. The discourses of intent show some variation between federal stakeholders. For example, discourses of ensuring public safety are almost entirely related to policy documents from PSC, who's mandate is to ensure coordination across federal departments to support national security and safety of Canadians. The PHAC—whose activities related to MHSUD are focused on promoting good physical and mental health[15] (Government of Canada, 2023)—has produced documents to move forward harm-reduction models of MHSUD care and to further preventative efforts. HC, by virtue of its

[15] Other mandates of The Public Health Agency of Canada include preventing disease and injuries and responding to public health threats (Government of Canada, 2023), which are beyond the scope of MHSUD responses.

funding and legislative roles in health care provision nationally, tends to span discourses of intent by both through awareness campaigns to support social ecological and bio-medical health understandings and also through direct funding of service provision pathways. Furthermore, of the eight documents utilizing service provision as a discourse-of-intent, five of these documents were aimed at Indigenous MHSUD responses and programs (which are funded federally unlike most MHSUD service delivery) and the other three were service delivery recommendations from the CCSA. In the cases in which discourses-of-intent focusing on financial and economic costs of MHSUD, this discourse was used to bolster arguments for harm-based and health-based responses to MHSUD.

In addition to themes related to specific stakeholders, we also see changes in themes over the examined time period (2013-2023). From an ACF perspective, the use of different discourses over time seem to indicate some changes in secondary beliefs—that is a change in policy interests, rooted in a change in underlying beliefs about the cause of a problem—either prompted by policy learning and/or by perturbations to the existing system (Auld & Morris, 2016). In particular, we see discourses of safety supported by discourses of "risk," "addiction," and "delinquency" most notably before 2016. After 2015, discourses of MHSUD as a public health or biomedical health issue correlates with the federal move in 2016 to have the *Canadian Drugs and Substances Strategy*, led by HC, replace the *Anti-Drug Strategy*, which was led by Justice (2007). This was a strong shift in treatment of MHSUD as a healthcare issue rather than a justice based one (though, PSC still funds public safety interventions for youth with MHSUD nationally). The Truth and Reconciliation Commission's (TRC) Calls to Action in 2015 and the end of Conservative government led by Stephen Harper in 2015 also prompted renewed federal conversations about colonialism and its influences on health and wellness (Landry, 2020).

Furthermore, the emergence of socio-ecological models of health as an alternative to biomedical or public health understandings of health takes root at this time, entrenched by Canada's commitment to the World Health Organization's *Rio Political Declaration on Social Determinants of Health* in 2012 (Government of Canada, 2023). This was partnered with increasing federal action and public understanding around decriminalization after 2015 (Government of Canada, 2016) and harm-reduction models rooted in socio-ecological and cross-sector approaches to mental, physical, and social health become a dominant federal paradigm of intent when responding to MHSUD in general and MHSUD with youth in particular (CPHOC, 2021; PHAC, 2020). These most recent shifts from a safety discourse to a health care/treatment discourse to a harm reduction discourse demonstrate a shift from single-sector ownership of a policy issue to multi-sector ownership of a policy issue and opens the door for increasing policy coordination.

Federal Discourses of Action: What strategies and venues do stakeholders use to achieve their objectives? Who controls critical resources? In this section, I explored discourses of action by mapping out policy actions associated with each discourse of intent. Policy actions at the federal level take the form of: commitments to action, declarations of intent, funding transfer agreements, public reporting on outcomes, and pilot programs. I broke these policy actions down into material and symbolic policy actions to compare the types of actions that support the discourses of intent. Table 5.5 presents the policy actions associated with discourses of intent, organized by policy actor.

Table 5.5 Policy Actions Associated with Discourses of Intent in Federal Documents

Federal Discourses of Intent *Timelines Document Codes*	**Policy Actor Supporting this Discourse-of-Intent**	**Policy Actions Associated with Discourses of Intent**	
		Material Policy Actions	**Symbolic Policy Actions**
Minimize harms from MHSUD by treatment as a cross-sector issue *2018-2023* *F1, F2, F3, F10, F11, F19, F25, F26, F30, F31, F34*	**Public Health Agency of Canada**	• Funded pilot program of Icelandic Prevention Model (community-driven primary prevention program) (2022)	• Call to school communities to institute community-connected, trauma-informed skills development by "leveraging the strengths and reach of school communities (2021a, p. 1)." • Call to K-12 education to take on socio-ecological models of MHSUD in: curricula, health programming, extra-curricular programming, safe/inclusive spaces, food programs, protective factors, community partnerships, harm reduction messages (2021b) • Call to forge new coordination partnerships in MHSUD with coordination exemplars (2019b) • Advocacy for collaboration among cross-sector service providers (2019c)
	Assembly of First Nations	None identified	• Commitment to a continuum of care following a national forum: community development, universal prevention and health promotion, early identification, brief intervention and aftercare, secondary risk education, active treatment, specialized treatment and care facilitation
	Health Canada	• Public consultation for Canadian Drugs and Substances Strategy – survey data, literature review and data review (2019) • Bridge funding and legislative actions by other sectors: - Funding *Strengthening Families* Policy Initiative - Funding federal Housing-First Initiative - Decriminalization legislation • Targeted funding to provinces to improve home and community care and MHSUD services (2018) • Stigma reduction campaigns (2018)	• Policy Paper outlining Canada's policy approach to substance use as rooted in the Canadian Drugs and Substances Strategy (2019)
	Canadian Center for Substance Use and Abuse	None identified	• Education resources for educators (2022) • Literature review: rapid and coordinated access models, hospital treatment models, mobile outreach teams, screening, assessment and brief intervention/referral models, integrated youth services (2020) • Best practices for service providers to support collaboration (2015)
	Joint Consortium for School Health	None identified	• Call to strengthen connections between ministers of education and health and engage with federal initiatives, NGOs and stakeholders to advance Comprehensive School Health based approaches • Provide policy and practice-based tools for implementation to support comprehensive school health
Treatment of MHSUD as a Public or Biomedical Health Issue *2015-2020* *F8, F12, F13, F14,*	**Chief Public Health Officer**	Link to policy actions from other sectors (2018), including: • Canada's Poverty Reduction Strategy • Housing First Initiative • National Housing Strategy • Indigenous Early Learning and Child Care Framework • Cannabis Act • Canadian Drugs and Substances Strategy	Link to policy actions from other sectors (2018): • First Nations Mental Wellness Continuum Framework (Health Canada) • Public Health Pyramid and Public Awareness Campaigns (Public Health Agency of Canada)
	Health Canada	• Funds transfer to provinces for health care provision, legislate access to healthcare services (2017)	• Commission a report on opioid crisis; recommendations on next steps to support 2016b)

		• Transfer Payment Programs: Strengthening Canada's Home and Community Care Mental Health and Addiction Services Initiative (2016a) • Anti-stigma campaigns, mental health strategy • Canadian Drugs and Substances Strategy (2016a)	
Service Provision for MHSUD *2012-2022* *F9, F15, F16, F17, F18, F27, F28, F29, F33*	**Health Canada**	• Funding to support existing substance use systems, including: drop in centres, investments in new programming models, revising curriculum to include Indigenous perspectives, "treatment" centers via a "principle of recovery" (2022) • Funding of inpatient, outpatient, specialized services and substance use treatment (2012)	None identified
	Indigenous Services Canada	• Jordan's Principle: funding for social, medical, educational expenses for First nations youth • Fund 10 national youth solvent additions programs	None identified
	Assembly of First Nations	None identified	• Information document on Jordan's Principle: service provision to First Nations children, even when service is not available to other children
	Center on Substance Use and Abuse	None identified	• Policy directive: collaboration across sectors and with community (2015) • Policy directive on "Principles of Recovery" and implications for supportive policy frameworks to support recovery (2017) • Policy paper: Clinical Tools Screening – assessment-treatment/ brief intervention/withdrawal management/medication assisted therapy/ psychosocial treatment with best practices for specific clinical tools (2016) • Policy paper outlining: Education, training, continuum of care, multiple-treatment options, community-based support programs, plans to support transition to long term recovery, cross-sectoral collaboration (2012)
Primary Prevention *2012-2019* *F4, F5, F6, F7, F32*	**Public Health Agency of Canada**	None identified	• Policy Paper: Promote wellbeing, create welcoming environments integrate effective programs using Comprehensive School Health • Policy paper: School-based universal supports to strengthen protective factors among youth to prevent MHSUD • Policy Paper: Diversity training and anti-racism supports to create welcoming school environments and prevent MHSUD • Policy Paper on Mental Health assist; social emotional skills development
	Center on Substance Use and Abuse	• Legislation documenting the role or CCSA as an advisory, research, review organization to support government of Canada decision (2012)	None identified
Ensuring Public Safety *2011-2015* *F20-24*	**Public Safety Canada**	Local (pilot) projects funded by PSC but run locally: • mentorship programming to support: counselling, pro-social skills, job skills, education support, recreation • wraparound support and planning for youth • building protective factors and coping strategies • youth workshops • alternative to suspensions in youth with violent behaviour/drug use	None identified

Symbolic and Material Policy Actions. As discussed in the previous section, a discourse theme of cross sector responses to MHSUD rooted in harm reduction methods was the dominant discourse of intent found in the federal documents. The majority of the policy actions associated with this discourse of intent are symbolic in nature, taking the form of position papers, advocacy-based documents, and declarations of policy action explicating socio-ecological framing of the policy problem, rather than formal legislation or material policy implementation. Only a single pilot program (PHAC, 2022) and HC's, *Drugs and Substances Strategy,* were linked with material policy actions in this discourse of intent. Furthermore, most of the policy actions related to HC's material responses as part of the *Drugs and Substances Strategy* – the Housing First Initiative, decriminalization efforts—are only peripherally responsive to MHSUD needs. Alternately, understandings of MHSUD as a public health issue were most commonly associated with material responses, including transfer payments for program funding, MHCC's Contribution Program and additional reference to the federal *Drugs and Substances Strategy*. The discourse of intent of service provision was supported by both symbolic policy actions—primarily policy directives—and material policies—in the form of funding, pilot programs, and Jordan's Principle funding for service provision. Discourses of safety were also supported solely by material policies, which funded regional program initiatives. Discourses of prevention were supported solely by symbolic policy actions through policy papers and calls to action.

This is noteworthy, in that while much of the federal policy work around youth MHSUD in the last five years has been entrenched in harm reduction intents rooted in socio-ecological models of health, this discourse does not seem to be supported via material policies federally aside from HC transfer payments to provinces which have included, in recent years, mandates specifically related to MHSUD. For example, HC's transfer payment program, *Strengthening*

Canada's Home and Community Care and Mental Health and Addictions Services Initiative (2016a), identifies that in order to receive the transfer payment, provinces and territories are responsible for

> expanding access to community-based mental health and addiction services for children and youth (age 10-25), recognizing the effectiveness of early interventions to treat mild to moderate mental health disorders; spreading evidence-based models of community mental health care and culturally-appropriate interventions that are integrated with primary health services; and, expanding availability of integrated community-based mental health and addiction services for people with complex health needs. (HC, 2016, Subsection: Priority Areas for Cost-Share)

However, even in the context of this transfer payment program, the caveats placed on provinces and territories to implement more robust MHSUD supports are rooted in a public health model of MHSUD with responses to MHSUD rooted in "health care," "services," and "interventions." Missing are socio-ecological understandings of the social, educational, mental health supports. In sum, while recent advocacy work from the federal government is rooted in harm-reduction intents and socio-ecological models of health, material policy action reflects health and safety-based discourses and therefore tend to be relegated to health and justice responses.

Action-based discourses in relation to schools. I also reviewed signifiers to identify policy actions that were associated with schools. Of the examined federal stakeholders, actions in relation to schools were primarily present in symbolic policy actions, namely, by the PHAC, CCSA, CPHO and the JCSH. The only exception is PSC's material policy actions in the form of federally funded pilot programs involving local school communities. Most often connected to discourses of harm reduction and socio-economic models of health, discussions of MHSUD

supports rooted in school communities are particularly prevalent in policy documents published since 2017. Using a more holistic understanding of wellbeing, these policy documents acknowledge that, "Connectedness to school, positive relationships with caring adults inside and outside the family, supportive peers, as well as school and community safety, can all enhance an individual's ability to cope" (PHAC, 2021a, p. 35). PHAC, CCSA, CPHO and the JCSH all call for "prevention interventions, programs to teach resilience, social emotional skills" within schools (PHAC, 2021b, p. 35).

In general, actions posited by the PHAC, CPHO, CSA and JCSH are aligned in their call for schools and subregional stakeholders to implement community based, trauma-informed skills development with the aim of increasing wellbeing and supporting emerging MHSUD issues. However, insofar as the federal government does not legislate education, these federal stakeholders seem to be taking a leapfrog approach in affecting policy change by advocating to regional organizations to rally to provincial bodies to inform such change. The call for "all levels of government as well as nongovernmental, private, and philanthropic organizations across sectors — including public health, primary health care, social services, justice, and education — to undertake a coordinated approach to preventing problematic substance use among youth" (CPHO, 2018, p. 38) is a strong one. However, without top-down imperatives to coordinate across sectors and without any material policy actions allocating additional resources and funding for schools to pick up what has predominantly been framed as a health issue. This comes across in the document as follows: "the existence and effectiveness of school health and wellbeing initiatives rely heavily on the champions within the school community who can get these initiatives off the ground and generate buy-in from other members of the school community" (PHAC, 2021, p. 23). Essentially, in lieu of directives including provincial

governments, local and regional actors are being encouraged to provide front line services without material legislation providing additional funds or resources.

Federal discourses of coordination. To identify discourses of coordination, I coded for existing coalitions, vertical and horizontal coordination structures, evidence of policy integration and service coordination, and the presence of barriers and catalysts to coordination. Table 5.6 outlines discourses of coordination for each identified discourse of intent, by policy actor.

Table 5.6 Coalitions, Types of Coordination and Barriers to Coordination in Federal Documents (collated by discourse of intent)

Federal Discourses of Intent *Timelines* *Document Codes*	**Policy Actor Supporting this Discourse-of-Intent**	**Coalitions – existing partnerships with policy actors**	**Opportunities or Barriers to coordination (By policy actor)** **V=vertical H=horizontal**	**Low level service coordination or policy integration**	**Opportunities and Barriers:** • **Shared Values /Lack Shared Values (SV/LSV)** • **All Policy Actors Present (APAP)/Policy Actors Not Present (PANP)** • **Fidelity Implementation (FOI)/ Lack of Fidelity Implementation (LFI)** • **Funding Decisions at Same Level (FDSL)/ Funding Decisions at Different Levels (FDDL)**
Minimize harms from MHSUD by treatment as a cross-sector issue *2018-2023* *F1, F2, F3, F10, F11, F19, F25, F26, F30, F31, F34*	**Public Health Agency of Canada**	**Federal/ National** • School Matters Forum • Joint Consortium for School Health • Canadian Center for Substance Use and Addiction **Provincial** • None noted **Regional** • United Way (NGO) • School boards • University partners	Vertical	Policy Integration	**SV** • Shared values documented across horizontal stakeholders, but all recommendations are vertical in nature. **PANP:** • PHAC recommends school health and wellbeing initiatives to be initiated by "**champions** within the school community who can get these initiatives off the ground and generate buy-in from other members of the school community. (2021b, p. 23). School communities do not have input. • "School community" as a signifier referenced 19 times while provincial government (who legislates education) is not mentioned (PHAC, 2021b) **FDDL, LFI** • Federal engagement of school communities, community organizations, public health are local level actions – funding decisions are provincial • PHAC program frameworks not a mandate or a funding provision; schools being asked to form community partnerships, but no additional resources being allotted to form partnerships
	Assembly of First Nations	**Federal** • National Native Alcohol and Drug Abuse program • First Nations and Inuit Health Branch of Health Canada • National anti-drug strategy **Provincial** • None noted **Regional** • None noted	Horizontal	Service coordination	**SV, FOI** • Federally funded initiatives share a shared vision between participating agencies and sectors. Because funded and regulated vertically and single sector, fidelity of implementation at regional levels monitored **PANP, FDDL** • "Continuum of Care", including community development, universal health promotion, early identification, brief interventions, secondary risk education active treatment and specialized treatment is facilitated by both provincial legislation and regional service providers, but funded both federally and provincially.
	Health Canada	**Federal** • Joint Consortium for School Health • Canadian Institutes of Health Research • Canadian Center on Substance Use and Addiction • Drugs and Substances Strategy • Strengthening Families Initiative	Horizontal – federal initiatives dealing with MHSUD Vertical – Funding Transfers	Policy Integration	**LSV** • Health Canada advocates health-only responses to MHSUD but also calls for collaborative approaches **PANP** • "deficit of coordination between health, social and law enforcement services…intersecting social systems can be difficult to navigate" (2018, p.15) • Private care providers not regulated and service varies (2018) • Though CPHO and PHAC cite the role of schools in supporting MHSUD, HC makes no mention of schools: "Justice, Health Care and other social systems to address problematic substance use a s a health and social issue" (p.7) **FOI**

		• Housing-First Initiative • TRC Calls to Action • Controlled Drugs and Substances Act • Good Samaritan Drug Overdose Act • First Nations Mental Wellness Continuum • Honouring Our Strengths: A Renewed Framework to Address Substance Use • Thunderbird Partnership Foundation **Provincial** • Federal funding to provinces **Regional** • None noted			• Federal mandates funded and implemented federally have strong implementation
	Canadian Center on Substance Use and Abuse	**Federal** • Council on Addictions • Mental Health Commission of Canada **Provincial** • None noted **Regional** • School boards • Local service providers • Regional Universities	Vertical – advocacy to lower-level policy actors	Policy Integration – call to develop school-based supports for MHSUD	**PANP, FDDL** • Skips provincial stakeholders with policymaking – national recommendations made to local level without mandates to provinces • States that Provincial jurisdictions struggling to manage this burden of risk • Waitlists, siloes services seen in regional service provision. **LFI, LSV** • Exemplars of collaboration between sectors are site-specific and lack any guiding mandates
	JCSH	**Federal** • Health Canada **Provincial** • Ministers of Education • Ministers of Health **Regional** • None noted	Horizontal—between provincial health ministries Vertical—Health Canada recom-mendations	Policy integration – looking at supporting cross-sectoral MHSUD programming in schools	**SV** • Shared vision of Comprehensive School Health to supporting youth MHSUD **APAP** • Engage with federal initiatives • Engage NGOs and stakeholders to advance Comprehensive School Health • Includes provincial ministers capable of making legislative change, though JCSH itself is non-legislative
Resolution/ Treatment of a Public Health Issue – MH/PH *2015-2020* *F8, F12, F13, F14,*	Chief Public Health Officer	**Federal:** • First Nations Mental Wellness Continuum • Public Health Pyramid • Poverty Reduction Strategy • Housing First Initiative • National Housing Strategy • Indigenous Early Learning and Child Care Framework • Cannabis Act • Drugs and Substances Strategy **Provincial**	Horizontal – cross federal initiatives Vertical – call for multi-sector, multi-level responses	Policy Integration – call for multi-sector treatment of a common public health concern	**FDSL** • Decriminalization, Housing Strategy, Canadian Drugs Strategy are federal – funding decisions made alongside CPHO **FDDL** • Call for prevention interventions, programs to teach resilience, social emotional skills" (p. 35) in schools – provincial funding **PANP** • Though multi-level responses are examined, only federal actors are part of the document. • Large emphasis on the roles of schools; no school stakeholders represented in the policy document **LFI**

		• None noted			• Calls for horizontal coordination between health, education, social services are made without investigation into how collaborations would work at the grass roots levels
	Health Canada	**Federal** • Canada Border Services • Canada Revenue Agency • Institutes of Health Research • Correctional Service Canada • Indigenous Services Canada • Department of Justice • Financial Transactions and Reports Analysis Centre • Global Affairs Canada • Parole Board of Canada • Public Health Agency • Public Prosecution Service • Public Safety Canada • Public Services and Procurement Canada • Royal Canadian Mounted Police **Provincial** • Federal funding transfers **Regional** • First Nations	Horizontal – cross-federal initiatives Vertical – via funding transfer to provincial governments	Policy integration Service provision – via funding transfer	**FDSL** • Funding transfers with mandates to provincial governments; transfer conditional upon meeting certain outcomes; HC could make other conditions **PANP** • Recommendations to provinces **FDSL, SV, FOI, APAP** • Canadian Drugs and Substances Strategy an example of policy integration with all catalysts to coordination: Strategic Plan across multiple stakeholders; strategic plan, shared mandate, timeline to implement changes to mandates in individual organizations to align, one director overseeing, expected results for each individual service sector.
Service Provision for MHSUD *2012-2022* *F9, F15, F16, F17, F18, F27, F28, F29, F33*	Health Canada	**Federal** • Federal Substance Use and Addictions program (SUAP) **Provincial** • None noted **Regional** • Regional community projects and service providers	Vertical – coordination via funding transfer	Service Provision – via funding transfer to support programming	**FOI, FDSL** • Coordination via funding transfer, local organizations maintain control of funding to initiate decisions **FDDL** • Federal service provision regionally, though provinces legislate PANP • "Treatment" based language throughout rooted in a 12-step process. No mention of culturally reflective supports –
	Indigenous Services	**Federal** • National Native Alcohol and Drug Abuse Program • Health Canada • Assembly of First Nations **Provincial** • None noted **Regional** • Youth solvent programs • Regional service providers	Vertical – funding individual services via federal government	Service Provision – via Jordan's Principle	**FDDL** • Funding source federally to the individual, provincial legislated services and regional service providers are not part of policy development; funded federally run locally

	Assembly of First Nations	**Federal** • First Nations Child and Family Caring Society • Human Rights Tribunal **Provincial** • None noted **Regional** • None noted	Vertical – funding individual services via federal government	Service Provision – Jordan's Principle	**FDDL** • Funding source federally to the individual, provincial legislated services and regional service providers are not part of policy development; funded federally run locally
	Canadian Center on Substance Use and Abuse	**Federal** • National Recovery Advisory • Recovery Expert Advisory • *Life in Recovery* Survey **Provincial** • None noted **Regional** • Stakeholder consultations	Vertical – national recommendations to regional audiences	Service provision – focus on treatment and "principles of recovery" and specific service provision	**PANP** • Alcoholics Anonymous related language – one pathway to treatment • No mention of Indigenous ways of knowing or culturally reflective supports – even after referencing the success of Fist Nations programs in 7.5% of survey sample
Primary Prevention *2012-2019* *F4, F5, F6, F7, F32*	Public Health Agency of Canada 4, 5, 6, 7	**Provincial** • None noted **Regional** • Western center for school mental health	Vertical – recommendations to schools	Service provision-recommendations related to services offered	**FDDL, PANP** • Sub-regional actions – universal strategies for all students. • Call to subregional actors: administrators, teachers, school communities – funded and legislated provincially • Advocate for partnerships with community agencies – no funding to support this
	Canadian Center on Substance Use Abuse	**Federal** • Government of Canada **Provincial** • None noted	Vertical – federal directive to promote awareness	Policy integration – intended to	**SV** • CCSA appointed in Canadian Center on Substance Abuse Act to promote awareness to multilevel stakeholders
Ensuring Public Safety *2011-2015* *F20-24*	Public Safety Canada	**Regional** • school boards • Urban Native Youth Association • Regional police departments • Regional health authorities • community service societies • Local NGOs			**FDDL, LFI** • Federally funded regional service programs are parachuted into existing policy subsystems. Federal programs run via grants do not work collaboratively with the existing services offered through provincial legislation. • Programming run in schools; RCMP administered

As shown in Table 5.6, existing federal coalitions are seen across all levels of governance. Federal coalitions with other federal stakeholders exist between federal ministries (for example, with Corrections Canada or Border Services), national level advisory organizations (for example, JCSH or CCSDA), and federal research initiatives including federal frameworks. Regional coalitions are also common, though in general, they exist not as policy partnerships, but in the forms of funding of regional and pilot programs. The presence of provincial policy partners was found to exist in only two cases. In fact, though seven of the examined stakeholders (PHAC, HC, CCSA, JCSH, CPHO, ISC, AFN) advocate for vertical coordination to meet their policy goals, in general they leapfrog provincial stakeholders and make recommendations or run pilot programs at the regional level. Furthermore, of these seven stakeholders, five of them (PHAC, HC, CCSA, JCSH, and CPHO) call for large-scale policy integration (rather than merely service coordination), despite the lack of coordination with provincial bodies. The federal government has ample history funding service delivery and service integration through funding transfers and legislative mandates (White, 2012). However, outside of HC funding transfers, there is a notable lack of coordination with provincial level governments in the policy subsystem of MHSUD.

Of the 34 federal documents examined, only HC via funding transfer and JCSH via consultation with provincial ministers, employs vertical coordination with provincial partners. HC includes provincial partners as a one-way coalition, by virtue of the transfer payment program legislated through the *Canada Health Act* in which HC provides funds transfers to provincial ministries of health. The JCSH is a non-legislative body and cannot leverage any direct mandates to provincial bodies. Rather, the JCSH relies on provincial bodies partnering funding dollars—from Ministries of Health and Education—and policy recommendations which

are inconsistent from province to province. For example, in Manitoba JCSH policy impact takes the form of a *Healthy Schools Grant* where ministers pledge funds to support student health in keeping with JCSH recommendations (Government of Manitoba, 2023). Whereas next door in Saskatchewan, the JCSH is referenced solely as a thinktank with resources for families (Government of Saskatchewan, 2023).

In general, although cross-sector responses to MHSUD rooted in socio-ecological health was found to be the most recent and progressive discourse of intent in the federal data set, it is bogged down by a lack of fidelity of implementation and a lack of shared vision between policy actors and levels of governance. While HC—the federal actor with the most legislative power in MHSUD discourses—does enter into discourses of socio-ecological health by calling for collaborative approaches, HC itself forwards health-only responses and the only cross-sector efforts at coordination include references to already-implemented federal policy dealing with broader social and educational gaps. For example, while HC calls for "a wide range of civil society groups also play a role, including professional medical associations, universities and research-based organizations, local public health units, harm reduction organizations, and stakeholder groups" (2018, p. 7), HC admits to a "deficit of coordination between health, social and law enforcement services" (2018, p.15). This is demonstrated in a lack of shared vision between federal actors for regional and provincial systems. The fact that the majority of socio-ecological policy actions related to MHSUD at the federal level are symbolic in nature—primarily in recommendations to action from PHAC, CCSA and the CPHOC—suggests that these policy beliefs are still new and that these deep core beliefs are not yet embraced or understood by all areas of the policy landscape.

However, in terms of indicators for effective coordination, the vertical coordination present in HC's transfer payment programs shows strength insofar as it ties particular values and service-provision frameworks with real dollars and ensures that specific transfers are tied to particular norms and expectations. In this way, mandates laid out federally can be linked with fidelity of implementation at the provincial level by virtue of funding mandates. Insofar as the federal government deputizes the provincial ministries with considerable autonomy (Vergari, 2010), Health Canada's transfer payment programs such as, *Strengthening Canada's Home and Community Care and Mental Health and Addictions Services Initiative* (2022), provide a pathway for federal priorities to carry through to the provincial level.

Aside from this key vertical provincial policy coordination pathway, the majority of vertical service provision was federal to regional in nature, skipping provincial stakeholders and adding stakeholders to the regional landscape of service provision. For example, PSC parachutes service delivery programs into provincial systems in addition to the service delivery frameworks and regional partners already in place. In many cases, this takes the form of RCMP officers implementing MHSUD programming alongside existing programming overseen by provincial ministries of health and regional health authorities or social services (PSC, 2016). Similarly, the introduction of Jordan's Principle funding, whereby federal funding coordinators support individuals to access services in provincial and regional service delivery frameworks (ISC, 2018), inserts federal stakeholders to regional and provincial landscapes.

In terms of horizontal coordination, the pan-federal *Drugs and Substances Strategy* (2015), is perhaps the strongest exemplar of horizontal policy coordination. Multiple independent offices share this mandate with a strategic plan marked with: one overseeing director, clear funding dollars, accountability mechanisms for individual sectors, pre-determined

strategies, and a pre-established timeline (Government of Canada, 2023). Though led by Health Canada, other federal stakeholders—including PSC, PHAC, Department of Justice—have a shared vision and contribute funding dollars and service goals. This inclusion of communicative instruments, in the form of strategic plans and visions; organizational instruments, in the form of task forces and amalgamation of departments; and procedural instruments, in the form of shared budgeting and assessments of success are consistent with the tools Hogl and Nordbeck (2012) ascribed to successful coordination relationships. Therefore, this exemplar presents a promising practice in terms of recommendations to other coordination relationships.

Coordination and collaboration with Indigenous Communities and the TRC Calls to Action. The Truth and Reconciliation Commission of Canada's Final Report has several Calls to Action related specifically to wellness and harm reduction. In particular, Call to Action 19 states:

> We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services. (Government of Canada, 2021, p. 18)

That is, actions to reduce gaps in MHSUD outcomes for Indigenous youth ought to be a primary focus in MHSUD legislation. Further, Call to Action 21 states,

> We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of

> Aboriginal patients in collaboration with Aboriginal healers and Elders, where requested by Aboriginal patients. (Government of Canada, 2021, section 18).

Given these calls and given the intentions enshrined within the treaties, collaboration with Indigenous governments and stakeholders both to close the gap on wellness outcomes and to incorporate Indigenous models of health and healing are vital.

Health Canada states that MHSUD is a "shared responsibility between all levels of government, in collaboration with a wide range of civil society partners and stakeholders" (Health Canada, 2018, p. 7) and that "the federal government works with First Nations and Inuit peoples to support access to culturally-appropriate mental wellness and substance use treatment services" (Health Canada, 2018, p. 16). However, despite these declarations at the federal level, there are very few existing coalitions or calls for material policy actions which support policy coordination with Indigenous groups and governments. In general, discussion of coordination between the federal government and Indigenous governments exist in only three areas: (1) in symbolic policy actions associated with socio-ecological models of health where culturally relevant and reconciliation-based consultation is cited as important to Canada's pathway forward with MHSUD (CPHO, 2018; CCSA, 2020; PHAC, 2022); (2) in service provision and funding sources related to ISC funding of substance use services specific to Indigenous populations (most of which are rooted in public health binaries of diagnosis and treatment rather than in socio-ecological models of health, as discussed above) (ISC, 2019); and (3) in discourses of public-health where Jordan's Principle funding is cited as a universal access point for Indigenous service provision (ISC, 2023). That is, despite increased public acknowledgement of: Indigenous ways of knowing, Indigenous health care perspectives, and the need for culturally competent

care; there is not policy data to suggest that these perspectives have yet been embedded in material federal policy and legislation supporting MHSUD.

Key takeaways from the federal documents. In the federal data set, there are key takeaways that influence the broader national subsystem of MHSUD policy. First, the shifting discourses of intent in federal documents over the past decade from discourses of safety to health to socio-ecological health underscore shifts in the interests and beliefs inherent in MHSUD policy actions in Canada. Specifically, I examined how discourses of securing safety (by Justice Canada) shifted in 2015 to discourses of biomedical health and public health responses (by Health Canada). More recently, since 2018, federal policy documentation has shifted to discussions of MHSUD as socio-ecological health issue, where responses to MHSUD are centered in cross-sector responses acknowledging health, social, cultural, educational, and harms-based factors in service provision. I also documented how these socio-ecological models are primarily present in symbolic policy actions such as commitments to action, calls to action by lower level governments, and statements of belief. This suggests that this most recent shift in secondary beliefs has not yet permeated the entire federal policy subsystem, in which material policy actions still tend to be mixed in discourses of biomedical responses to MHSUD, safety-based responses to MHSUD, and service-provision and treatment models of MHSUD.

A key takeaway is that while numerous federal stakeholders call for schools and community-based stakeholders to take the lead on implementing mental health and trauma-informed skill development to increase wellbeing and support for MHSUD issues, this represents a leapfrog approach in affecting policy change. This means that the federal bodies encourage regional organizations to rally provincial bodies to inform such change. Neither schools nor provincial ministries of education have been part of these recommendations, and federal

directives to schools lack teeth when they are lost in a multi-level system in which provincial bodies direct regional actions.

Federal policy actors take a lead role in developing symbolic policy documents to recommend, provide exemplars of, cite pilot programs for, and assert an evidence base for cross-sector responses to MHSUD rooted in models of socio-ecological health. However, actual coordination relationships and coalitions are rare. We do see a promising practice in vertical coordination via HC's transfer payment program in which federal funds are tied to mandates at provincial levels of policy enactment to ensure fidelity of implementation. However, such a strategy lacks reciprocal engagement with provincial stakeholders and, thus, can only be employed as a one-way provision of both funds and values. A promising practice employing horizontal coordination was seen in the federal *Drugs and Substances Strategy (2015)*, in which multiple ministerial sectors developed a shared vision and mandate for coordinated action with indicators of success. The material actions outlined in the strategy were actionable, grounded in mandates of each of the policy actors and not symbolic declarations of intent. However, by virtue of a lack of a federal ministry of education or social services, this horizontal strategy is limited to policy actions related to health care funding, pilot projects, justice-based and decriminalization efforts, and housing strategies.

In terms of collaboration with Indigenous governments, I noted a lack of reciprocal planning and strategic policy actions that included Indigenous groups at the federal level. While symbolic policy actions commitment to working with Indigenous peoples to respond to MHSUD in socio-ecological models of health (*An Act Respecting First Nations, Inuit and Métis Children, Youth and Families*, 2019), material policy actions supporting Indigenous peoples were mired in biomedical discourses of diagnosis-and-treatment and provision of funding to standalone

programs. For example, a recent announcement by the PHAC touting MHSUD supports for Indigenous peoples boiled down to a policy action of increased funding to existing regional program models (PHAC, 2023) rather than a systemic strategy. While there is strong symbolic policy and directives regarding collaboration with Indigenous peoples and governments, the federal government seems to be delegating much of this to the provinces to legislate within existing health, mental health, education, and social services ministerial mandates.

Provincial Documents: Manitoba

In the Manitoban provincial context, 24 documents were reviewed from eight provincial policy actors, including:

- Manitoba's Ministry of Mental Health and Community Wellness (MB/MMHCW)
- Manitoba's Ministry of Health (MB/MH)
- Virgo Planning (MB/VP)
- Addictions Foundation of Manitoba (MB/AFM)
- Manitoba's Ministry of Education (MB/ME)
- Manitoba's Ministry of Families (MB/MF)
- Healthy Schools Manitoba (MB/HSM)
- Assembly of Manitoba Chiefs (MB/AMC).

Manitoban discourses of intent: What are the stakeholders' interests and beliefs? I followed the same process of CDA looking for signifiers and discourses of intent as I followed for the federal documents, above. At the provincial level in Manitoba, there were five identified discourses of intent in the policy documentation:

(1) treatment of MHSUD as a **cross- sector issue with intent to minimize harms**;

(2) treatment of MHSUD as a **biomedical public health issue**;

(3) treatment of MHSUD as a **social issue**;

(4) implementation of **safe schools**, and;

(5) administration of **appropriate educational programming**.

Table 5.7 outlines the key discourses of intent, and examples of the discourses of MHSUD which were used to support this discourse of intent.

Table 5.7
Discourses of Intent and Discourses of MHSUD in Provincial-Manitoban Documents Examined

Dominant Discourse of Intent *Document codes*	**Time-frame**	**Stakeholders Represented**	**Examples of Discourses of Interests Supporting the Discourse-of-Intent**	**Examples of Discourses of Beliefs Supporting Discourses of Intent**
Minimize harms from MHSUD by treatment as a cross-sector issue. *PM1, PM3, PM6, PM12, PM13, PM14, PM24, PM25*	2016-2023	MHCW AFM CPHO Virgo Planning	• A shared responsibility of "governments, communities, families and individuals" to support health and wellbeing…. harm reduction…. prevention…mental health… addiction" (MHCW, 2023) • "mental, physical, social and spiritual wellbeing", "combining and coordinating mental health, addictions and social services supports" (MHCW, 2022) • "reduce harms" (AFM, 2023) • "access to and coordination of services" (VP, 2018) • "the importance of collaboration across multiple stakeholders as a necessary condition for enhancing accessibility and effectiveness of services (VP, 2018) • Access range of services to help… children making a positive difference in their lives" (Government of Manitoba, 2019).	**Socio-ecological Health Issue** • Problem behaviours that result in harms (social, medical, emotional, physical, spiritual) (AFM, 2023; CPHO, 2016) • MHSUD care rooted in: mental wellbeing, emotional regulation skills, coping and problem-solving skills (Manitoba Healthy Schools Initiative, 2023) • "social emotional wellbeing " (Government of Manitoba, 2019) **Biomedical Health Issue** • Mental health a health issue (MHCW, 2022) • "managing mental health" (MHCW, 2022d) **Mental Health Issue** • Mental health, addiction, behavioural and emotional disorders (MHCW, 2023a)
Treatment of MHSUD as a Biomedical/Public Health Issue *PM2, PM4, PM5, PM7-PM11*	*2018-2022*	MHCW MHHLS	• "the delivery of public health services" (MHHLS, 2022) • health programs to "overcome anxiety, depression and stress" (MHSW, 2023b) • a "recovery-oriented system of care" (MHCW, 2022b) • "create a…system of wellness, mental health, substance use and recovery services" (MHCW, 2022c)	**Mental Health Issue** • "substance use and addiction challenges" (MHCW, 2022b) • "mental health and addictions" (MH, 2023) • "mental disorder" (MH, 2022a)
Treatment of MHSUD as a Social Issue *PM21-23*	*2006-2023*	MF Government of Manitoba	• "involuntary detention and short term stabilization for young Manitobans…. causing serious self-harm" (Manitoba Government, 2006) • Resolve problems in the community and family affecting youth (MF, 2023) • Services to families to "restore family functioning" (MF, 2022)	**Safety Issue** • Drug addiction, stabilization of health, severe, persistent use (Manitoba Government 2006) **Socio-ecological Health Issue** • Mental health in a social/community environment (MF, 2023) • "the mental, emotional, physical and educational needs of the child" (MF, 2022)
Safe Schools *PM16-19*	2017-2021	ME	• Programming and safety of all students (ME, 2021) • "safe and caring spaces for learning supporting… wellbeing, safety and learning" (ME, 2017) • Consequences for "violation of code of conduct" (ME, 2017)	**Safety Issue** • Unacceptable conduct and "concerns that have an impact on safety and wellbeing" (ME, 2017) • disciplinary consequences take into pupil "state of development (ME, 2021)
Appropriate Educational Programming *PM15, PM20*	2006-2022	ME	• adequate school accommodation… without discrimination based on mental disabilities (ME, 2022) • "enhance wellbeing of every member of the [school] community" (ME, 2022) • Principal's responsibility to supporting student with additional needs	**Educational Programming Issue** • evidence of "difficulty meeting outcomes" (ME, 2006) • "mental disability" – only as referenced via the Charter of Rights and Freedoms (ME, 2022) • "appropriate educational programming" for students with additional needs (ME, 2022)

Themes related to discourses of intent. Implementing cross-sector responses to MHSUD as a discourse of intent was evident in policy documents from Manitoba's Ministry of Mental Health and Community Wellness (MB/MMHCW), Addictions Foundation of Manitoba (MB/AFM), Manitoba's Chief Public Health Officer (MB/CPHO), and Virgo Planning's report of MHSUD in Manitoba. These documents all frame socio-ecological responses to MHSUD as policy intents. Spiritual, emotional, cultural, and social health are cited in this cross-sector representation of a policy problem (MB/CPHO, 2018, MB/MHCW, 2022d). For example, statements were made aiming to support "mental, physical, social and spiritual wellbeing…[through] combining and coordinating mental health, addictions and social services supports" (MB/MHCW, 2022a, p. 15). Within this discourse of intent, MHSUD was framed as (a) an issue of socio-ecological health, for example, rooted in mental wellbeing, emotional regulation skills, coping and problem-solving skills (Manitoba Healthy Schools, 2023); (b) a biomedical health issue, framing it as a health issue to be "managed" (MB/MHCW, 2022d) and (c) a mental health diagnosis acknowledging comorbidity of mental health, addiction, and behavioural and emotional disorders (MB/MHCW, 2023a).

In the Manitoban policy subset, cross-sector discourses of intent were primarily supported by stakeholders outside traditional ministerial sectors of health, social services, and education. Traditional ministries tended to be one-dimensional with discourses of intent rooted in their own ministerial mandates. For example, the discourse of intent of biomedical health provision was the only discourse of intent utilized by the Ministry of Health (MB/MHHLS). Within this discourse of intent, MHSUD was embedded in medical terminology with problematic substance use characterized as a "disorder" (MB/MHHLS, 2023). The discourse of intent of social service provision was supported by the Ministry of Families (MB/MF). Within

this discourse of intent, MUSUD was framed as a safety issue, whereby addiction was described as an issue of severity, stabilization, and safety indicating a threat to society (Manitoba Government, 2006, p.1), and as a social issue where social work supports take into account the needs of a child (MB/MF, 2022). Education-based documentation on MHSUD was split between two discourses of intent: (1) appropriate educational programming rooted in discussions of additional needs, where one of those needs is "mental disability" as referenced via the Charter of Rights and Freedoms (MB/ME, 2022); and (2) safe schools, characterized by discussions of unacceptable conduct and "concerns that have an impact on safety and wellbeing" (MB/ME, 2017, p. 4). Furthermore, both Virgo Planning and MB/MMHCW documentation included a secondary discourse of intent of reducing economic costs, referencing Manitoba costs for MHSUD (Virgo Planning, 2018) and an attempt to reduce costs associated with MHSUD (MB/MHCW, 2022a).

Varied discourses between stakeholders and changes over time. The MB/MMHCW is a relatively new entity, established in 2021, intended to bring cross-sector responses to MHSUD into effect in Manitoba under one ministry (2023). This followed calls to mirror other jurisdictions in a provincial response to addictions, mental health, and overdose deaths. The MB/MMHCW has advocated for the shared responsibility of "governments, communities, families and individuals" to support health and wellbeing…. harm reduction…. prevention…mental health… [and] addiction" (MB/MMHCW, 2022a, p. 4) and has defined wellbeing as being entrenched in "combining and coordinating mental health, addictions and social services supports" (MB/MMHCW, 2022a, p. 5). The embracing of cross-sector understandings of wellness and harm echoes a shift in understandings of MHSUD in the last decade (as discussed in the previous section) and also in the recommendations of the Virgo

Report (2018), a provincial audit of MHSUD policy and services which called for multi-sector involvement in addressing MHSUD. The Virgo Report determined that a "range of collaborative service delivery models are needed to knit [MHSUD] services closer together with… primary care services, justice, family, social services and education" (p. 228) to "increase the capacity of service providers both within and outside the mental health and substance use sectors" (p. 86).

The discourse of intent of medical service provision for MHSUD is a dominant discourse used in the provincial data set, which is arguably rooted more in recent provincial re-allocation of health supports. This reorganization followed the *Provincial Clinical and Preventative Services Planning for Manitoba* (MB/MHHLS, 2017) report, which recommended reconstruction of health services in Manitoba, rooted in changing understandings of MHSUD. Many of the policy documents supporting this discourse of medical service provision are documents which underscore strategic plans towards health care restructuring rather than as specific reponses to MHSUD. In these cases, MHSUD is named peripherally, often in press releases identifying how MHSUD goals are being supported amidst healthcare restructuring. That is, discourses of MHSUD seem to be a means to support advocacy of regarding healthcare restructuring, rather than being an end in and of itself.

The discourses of intents of social supports for MHSUD, maintaining safe schools, and appropriate educational programming in schools were supported by older documentation and do not seem to be influenced by the Virgo Report or by more recent shifts to understandings of wellbeing rooted in socio-ecological models of health. MB/ME did develop *Planning for Safety and Belonging* in 2018, in line with ideations of comprehensive school health as drawn from policy advocacy from the JCSH. However, this document contains no overt references to MHSUD and rather discusses mental health in a general context along with other student

planning needs to support school safety and student senses of belonging. Similarly, *Appropriate Educational Programming*, redeveloped in 2023, and outlining programming expectations for youth with academic and non-academic needs, also does not speak directly to MHSUD needs, supports, or struggles for youth in schools. These peripheral mentions of mental health as a factor that may influence school safety or individual student programming in education documents seem to indicate that policy shifts to understand MHSUD cross-sector issue of socio-ecological health have not yet permeated education policy directly in Manitoba.

Similarly, in the provincial documentation from the MB/MF, there is no specific mention of MHSUD aside from references that social supports ought to consider parental and youth mental wellness. For example, by stating that "agencies have a duty… to work with other human service systems to resolve problems in the social and community environment…. includ[ing] health services, mental health services educational authorities the police as well as other social services available to families" (MB/MF, 2016, p. 9). Considering this context, two key takeaways from the discourses of intent are that multi-sector discourses rooted in socio-ecological models of health do not seem to have permeated traditional provincial ministerial sectors outside of health and that the provincial social and educational contexts have thus far shied away from overt mentions and discussions of youth MHSUD.

Manitoban discourses of action. Policy actions at the provincial level in Manitoba take the form of position papers, funding or service provision from provincial ministries, provincial partnerships, audits, strategy recommendations, directives regarding alignment of services and legislative structures, and mandates regarding service provision within ministries. Table 5.8 outlines the policy actions associated with discourses of intent, organized by policy actor. As with federal stakeholders, I break policy actions down into material and symbolic policy actions

and I also investigate policy actions related to schools and policy actions in a multi-tiered system of support.

Table 5.8 Policy Actions Associated with Discourses of Intent in Provincial (Manitoban) Documents

Provincial (Manitoban) Discourses of Intent		Policy Actor Supporting this Discourse-of-Intent	Policy Actions Associated with Discourses of Intent	
			Material Policy Actions	Symbolic Policy Actions
Minimize harms from MHSUD by treatment as a cross-sector issue. *PM1, PM3, PM6, PM12, PM13, PM14, PM24, PM25*	2016-2023	**Ministry of Mental Health Community Wellness**	• Access points for MHSUD treatment/supports – inclusion of both governmental and non-governmental service providers • Provincial partnership with United Way to fund youth hubs as access points for youth MHSUD care	• Policy paper outlining provincial dedication to continue funding MHSUD service provision provincially. Commitment to develop service provision frameworks to improve equitable access, coordination, quality of care, Indigenous partnerships.
		Addictions Foundation of Manitoba	• Provision of residential, community-based, school-based and family-based support programs for MHSUD. • Educational resources to support youth with MHSUD	• None identified
		Chief Public Health Officer	• None identified	• Harm reduction position statement
		Virgo Planning	• None identified	• Audit and strategy recommendations regarding access to and coordination of (cross sector) MHSUD services provincially. • Recommendations include enhancing capacity for MHSUD care, developing a plan to expand MHSUD services in schools, implementation tiers of interventions/ a "continuum" of supports (2018, p. 48)
		Healthy Schools Manitoba, Government of Manitoba	• Provision of *Healthy Schools Grant* –to support: healthy eating, mental health, physical activity, injury prevention, sexual health, substance abuse • Funding of psychiatric nurses and wraparound facilitators to three rural school divisions for MHSUD supports.	• Education resources for educators on how to support mental health in schools
Treatment of MHSUD as a Public Health Issue *PM2, PM4, PM5, PM7-PM11*	*2018-2022*	**Ministry of Health and Community Wellness**	• Funding of *Strongest Families Institute* • Provincial funding to support specified addiction treatment programs provincially • Provincial funding to support hospital outreach, residential treatment and naloxone kit programs	• None identified
		Ministry of Health	• Realignment of authorities and service providers to reduce redundancies and strengthen access to health care services • Legislation mandating voluntary/involuntary admission criteria for residential mental health supports • Repeal Addictions Foundation of Manitoba Act; substance use services under provincial banner of Shared Health	• Outline powers of the provincial Minister of Health including setting up health authorities and regions, and the responsibility of authorities and regions • Legislation to mandate delivery of public health services
Treatment of MHSUD as a Social Issue *PM21-23*	*2006-2023*	**Ministry of Families**	• Mandate to Social Workers regarding CFS agencies' duties in responding to youth with needs, including MHSUD needs • Mandate of services to families supported by CFS agencies.	• None identified

		Government of Manitoba	• Implementation of an apprehension order to support detention of youth with severe and persistent substance use.	• None identified
Safe Schools *PM16-19*	2017-2021	**Manitoba Education**	• Mandate principal role in managing school site, including supporting disciplinary consequences for students and ensuring student safety • Mandate regarding school division Codes of Conduct to support disciplinary consequences for students	• Policy paper drawing on Comprehensive School Health model, as drawn from the Joint Consortium for School Health recommending school sites implement collaborative planning to support school safety and student belonging
Appropriate Educational Programming *PM15, PM20*	2006-2022	**Manitoba Education**	• Mandate to support educational programming of youth with additional needs in schools • Mandate roles of principal in supporting appropriate educational programming of all students	• None identified

Symbolic versus material policy actions. Given that provincial ministries are tasked with legislating and controlling service provision in health, education, and social services, it is unsurprising that the bulk of the policy actions uncovered at the provincial level are material in nature. However, there are some symbolic policies, some of which carry particular weight by virtue of their role as strategic plans mapping out long-term policy actions. Two key symbolic policies (Virgo Report (2018) and the MB/MMHCW, *Pathway to Mental Health and Community Wellness* (2022), serve as an audit of the existing MHSUD service provision frameworks and provide a legislative pathway forward respectively. Both of these documents uphold a discourse of intent of harm reduction through cross-sector approaches to MHSUD rooted in socio-economic models of health. MB/MMHCW, for example, calls for "work across sectors, levels of government and with our provincial government and system partners in MB/MHHLS, MB/ME, MB/MF and Justice to ensure that Manitobans have equal access to mental health, substance use and addictions supports" (MB/MMHCW, 2022, p. 5).

While the Virgo Report (2018) called for cross-sector material policy actions among "multiple ministries…[with] a high level of communication, trust and collaboration" (p. 160), this seems to have influenced predominantly symbolic policy actions supporting this vision via MB/MMHCW's, *Pathway to Mental Health and Community Wellness* (2022). The actual material policy actions that have followed these policy documents have tended to be single-sector in application. For example, funding e-mental health programs, treatment facilities, naloxone kit programs, health outreach programs, and withdrawal management programs are all run by healthcare and centered in healthcare facilities. The most profound demonstration of policy actions following the Virgo Report's call to overhaul MHSUD response has been in the redistribution of regional health authorities and the development of Shared Health Manitoba with

increased funding to regional mental-health initiatives (Shared Health, 2023). This has included the centralization of some services, including the repealing of the Addictions Foundation of Manitoba Act and the merging of other independently run provincial programs into a provincial health authority (MB/MHHLS, 2023).

While this revisioning of service delivery following the Virgo Report includes MB/MHHLS and MB/MMHCW, material policy changes have not extended to social services or education sectors. Though the Virgo Report recommended the development of an "integrated provincial plan to increase the coverage and coordination of services and supports provided to students in school, including, but not necessarily limited to, the work of the MB/AFM, the RHAs, MB/HCMO and mental health and addictions organizations" (p. 234), the symbolic policies calling for multi-sector and multi-pronged approaches do not seem to be upheld by material actions. For one, the MB/HCMO office, which the Virgo Report touted as "well-placed to take on a larger role in the coordination of important activities signalled by this system review, particularly coordination of school-based programs and suicide prevention for children and youth" (p. 232) was eliminated in 2020. The Virgo Report cites chronic underfunding for youth MHSUD, and the need for strategy for youth. In fact, the report cites that at current levels, only 5000 of 140,000 youth in need are able to access MHSUD services. As a recommended policy action, the Virgo Report advocates for a multi-sector tiered system of supports with a continuum of strategies at each tier, but the MMHCW does not map out a tiered response or address how multiple ministries might play different roles in a tiered response.

Material education policy actions orchestrated by MB/ME include directives regarding administration of schooling, codes of conduct, and codes of conduct where mental health is mentioned peripherally. For example, MB/ME (2022) acknowledges that schools often require

health care, social work, or justice to partner with schools to meet student programming needs. References to the Charter of Rights and Freedoms are made which calls for support of students "without discrimination based on… mental disability" (p. 4) but there are not overt policy directives regarding cross-sector MHSUD supports. Disciplinary actions require that schools consider "pupils state of development" (MB/ME, 2021, p. 15), but do not specifically mention mental health. Though there have been symbolic policies with commitments to develop service provision frameworks to improve equitable access, coordination, quality of care, and Indigenous partnerships in collaboration with health and education in the last five years, material policies do not yet seem to be cross-sector in nature. Material policy actions related to service provision, funding, and programming for MHSUD have been almost entirely centered within the MB/MHHLS and the MB/MMHCW with education involvement seemingly limited to the symbolic stage.

One rare example of a material policy action within education addressing MHSUD seems to be the *Healthy Schools Grant*, which is supported by Healthy Schools Manitoba. Healthy Schools Manitoba is a cooperative between the MB/ME and the JCSH which awards a small grant[16] to each school division to support a variety of health-related initiatives, one of which includes MHSUD. However, insofar as the grant is intended to support healthy eating, mental health, physical activity, injury prevention, sexual health, and substance abuse (Manitoba Healthy Schools, 2023), it is hard to argue that this is a material policy action directed at MHSUD as school divisions may be using this grant for any variety of purposes.

The MB/MF employ material policies which direct social workers and Child and Family Services (CFS) authorities in supporting either youth in care or families in crisis. Again, there is

[16] $5000 base and two dollars per student (Government of Manitoba, 2023).

peripheral mention of MHSUD in these contexts and MHSUD is rolled into health-care provision for youth. One key material policy under the discourse of intent of social supports is the Youth Stabilization Act (2006), which is implemented by Manitoba Justice but enacted by social workers and parents/guardians of youth at the provincial level. This act allows for the administration of an apprehension order and an involuntary hold in the Youth Addictions Stabilization Unit to support detention of youth with severe and persistent substance use. Though the apprehension order is initiated by parent/social worker and overseen by police services, the treatment programming that follows is overseen by Shared Health (provincial health authority). Other material policy actions from the MB/MF take the form of standards manuals and legislation outlining when and how CFS agencies become involved with youth. In these cases, MHSUD is mentioned peripherally as it is in education. For example, The Child and Family Services Act calls on CFS actors to consider "the mental, emotional, physical and educational needs of the child and the appropriate care or treatment or both to meet such needs" (2023, p. 8) but does not lay out particular material actions in response to MHSUD. That is, this data analysis shows that material policy actions in ministries of health, education, and families are aligned with the symbolic policy mandates in both the Virgo Report (2018) and the MB/MMHCW *Pathway to Mental Health and Community Wellness* (2022) documents.

Discourses of action related to schools. As discussed above, in Manitoba discourses related to coordinating MHSUD responses with/in schools tend to be symbolic in nature. This plays out in commitments to working alongside education sector in service of MHSUD supports (MB/MHCW, 2022) without firm obligation to action in this regard. That is, while other policy sectors reference collaborating with education (Virgo Planning, 2018; MB/MHCW, 2022), there is a paucity of actual material policy actions to support these symbolic gestures. From the

education sector itself, MHSUD is not overtly named in any of the examined policy documents except in conversations of disciplinary responses, suggesting that there is a noticeable lack of dedicated and directed supports for MHSUD. Discourses of support for MHSUD within the MB/ME tend to be coded in discussions of "belonging" (2017a), "appropriate programming" (2022a), "developmental capabilities" (2017b), and in mental health interventions veiled in discussions of social emotional learnings (2017a). This could be evidence of stigma surrounding MHSUD where curriculum, safe schools initiatives, and appropriate educational programming mandates all dealing peripherally with MHSUD without shared language or overt discussion of MHSUD in education.

The Virgo Report calls for a "provincial plan for scale-up of the youth hub model, or similar models of integrated youth services" (p. 233) but overlooks the possibility of integrated youth services being supported in schools. It may be that an absence of provincial literature marking out how tiered MHSUD supports can be or should be enacted in schools is a barrier to such service frameworks being aligned. As will be explored in the regional document analysis, schools and school divisions themselves develop a range of supports to meet youth MHSUD needs, but these seem to mostly be enacted with a lack of provincial direction or policy support.

Manitoban discourses of coordination. Table 5.9 outlines the existing coalitions, types of coordination, and catalysts/barriers to coordination present in the documents. At the provincial level, the majority of coordination mechanisms were found to be vertical in nature, in keeping with a federalist model where the federal government deputizes provincial governments to legislate regional and sub-regional bodies. However, when it comes to horizontal coordination at the provincial level, there were fewer coordination mechanisms in play.

Table 5.9 Coalitions, Types of Coordination and Barriers to Coordination with Provincial (Manitoban) Documents

Federal discourses of Intent *Stakeholders and Timelines Involved in the Discourse*	**Policy Actor Supporting this Discourse-of-Intent**	**Coalitions – existing partnerships with policy actors** **(By Policy actors)**	**Opportunities or Barriers to coordination** **(By policy actor)**		
			V=vertical H=horizontal	**Low level service coordination or policy integration**	**Opportunities and Barriers:** • **Shared Values/Lack of Shared Values (SV/LSV)** • **All Policy Actors Present (APAP)/ Not Present (PANP)** • **Fidelity Implementation (FOI)/ Lack of Fidelity (LFI)** • **Funding Decisions at Same Level (FDSL)/ Different Levels (FDDL)**
Minimize harms from MHSUD by treatment as a cross-sector issue. *PM1, PM3, PM6, PM12, PM13, PM14, PM24*	**Ministry of Mental Health and Community Wellness**	**Provincial** • Virgo Report • Manitoba Advocate **Regional** • Service Providers: Youth Addiction Stabilization Unit, Addiction Foundation of Manitoba, Teen Talk, Manitoba Adolescent Treatment Center, Marymound, Norwest Hub, Resource Assistance for Youth, Rapid Access to Addictions Medicine Clinics, Youth Drug Stabilization Unit • Illicit Drugs Task Force • Clinical and Preventative Services • United Way of Winnipeg	Vertical – funding provincial to regional Horizontal – coordination between providers	Service coordination – (material) policy actions funding service providers Policy Integration- (symbolic) policy paper on redesign of health care supports for MHSUD	PANP • Only "*RoadMap for Manitoba*" references socio-ecological systems or school-based systems and supports in policy actions FDDL • Only example of health-social collaboration is funding of regional United Way without collaboration with Ministry of Families LSP, PANO • Cross-sector/collaborative approaches are not represented in service providers listed for public; social services, education, justice mentioned as partners but not included at data collections stage: "We *will* work with education and social services…" [emphasis added] (MHCW, 2020) LFI • Strategic plan outlines general beliefs and commitments to cross-sector coordination, but does not include outcomes and strategies FOI Provincial to regional funding collaborations have coordination and accountability mechanisms
	Addictions Foundation of Manitoba *(As of 2023 part of Shared Health)*	**Provincial** • Manitoba Corrections • Healthy Child Manitoba **Regional** • MHSUD service providers • Some school divisions	Horizontal	Service coordination – partnerships with other regional providers	FDDL • AFM funded provincially, regional school divisions can choose to partner but then need to fund these partnerships out of regional education funds.
	Chief Public Health Officer	**Federal** • Canadian Harm Reduction Network	Vertical	Service Provision	• Position statement – no collaboration opportunities set out
	Virgo Planning	**Provincial** • provincial ministries related to MHSUD **Regional** • regional service providers	Horizontal – provincial coordination Vertical – funding	Advocating for both policy integration and service coordination to improve access	SV • Data collection shows redundancies, confusion in MHSUD system – emphasis on cross-sectoral strategies to improve service delivery PANP • Call for "systems approach" with "collaboration across multiple stakeholders" (p. 9); only inclusion of educational data was financial.
	Healthy Schools Manitoba, Government of Manitoba	**Federal** • JCSH **Provincial** • MHHLS • ME Regional	Vertical – regional service providers funded	Service Provision	FDSL • Schools can decide how to spend funding dollars, however grant is very broadly assigned – difficult how to measure what it is supporting. PANP

		• RHA's			• Health-funded MHSUD in schools not part of abroad strategic plan with all stakeholders present. Instead, a local partnership between provincial funders and local stakeholders.
	Assembly of Manitoba Chiefs	**Federal** • Jordan's Principle			
Treatment of MHSUD as a public Health Issue *PM2, PM4, PM5, PM7-PM11*	**Ministry of Health and Community Wellness**	**Federal** • CCSA • Health Canada **Regional** • Regional service providers Naloxone kit programs	Vertical – coordination funding transfer	Service Coordination	FDSL • single sector e-health • siloed health response PANP • revamp of medical system – repeal AFM act • single sector health care provision
	Ministry of Health	**Provincial** • 5 regional health authorities • Diagnostic Services Manitoba • *CancerCar*e Manitoba • AFM/ Shared Health	Vertical – realignment as directed by province	Service Provision – single sector realignment	PANP • While health sector admits that existing health care services plan "health services in relative isolation from one another, leading to duplicate services and inefficient service delivery" (MHHLS, 2022) the transformation team does not include any stakeholders outside of health sector
Safe Schools *PM16-19*	**Manitoba Education**	**Federal** • Joint Consortium for School Health **Provincial** • Healthy Child Manitoba **Regional** • school principals • regional police • AFM • Crime prevention programs • Anxiety clinic	Vertical – Planning for Safety and Belonging drawn from federal JCSH Comprehensive School Health documentation; provincial mandates for local schools to follow	Service provision-mandates for educational administration and planning for safe schools at the school-level.	PANP • Planning for comprehensive school health does not include health or social services partners – single sector undertaking. LSV • *Planning for Safety and Belonging* is rooted in comprehensive school health as laid out in the JCSH document; no mention of MHSUD • updates to safe schools documentation included planning for diversity and anti-bullying; there been no provincial directives around MHSUD LFOI • School teams to collaborate with outside service; there is no reference to adjustments in the administration of service providers to support. • "students, parents, school and community" (p. 12); this places no onus on provincial/regional bodies to coordinate to support collaborative groups
Treatment of MHSUD as a Social Issue *PM21-23*	**Ministry of Families**	None identified	n/a	n/a	• CFS agencies refer youth to treatment and supports for youth and families. MHSUD not overtly mentioned.
	Government of Manitoba	**Regional** • WRHA centralized intake • Police • Youth addictions services	Vertical – legislation to instruct regional policy actors	Service Provision – justice stabilization to support	PAP • Instruction to police, WRHA centralized intake for how to refer youth to stabilization unit – clear mandates to all service providers.
Appropriate Educational Programming *PM15, PM20*	**Manitoba Education**	**Provincial** • Child and Family Services • Interdepartmental Protocols **Regional** • Physicians, Speech-Language Pathologist, Elders, Clinicians, Physiotherapists, Occupational Therapists, Police	Horizontal	Service provision	LSV • While there are changes in language in other jurisdictions where health/ medical terminology is inclusive of physical and mental health, MHSUD is not overtly named as part of these regulations LFI • "use qualified practitioners and other service providers and involve parents to complete specialized assessments when appropriate" (p. 12)

In general, existing coalitions reflect vertical governance models in which federal directives inform provincial ministries to then organize regional service providers. As discussed in the previous section, only two documents, which are symbolic policies rather than material policy actions (*Pathway to Mental Health and Community Wellness* (2021) and the Virgo Planning document (2018)) referenced socio-ecological systems and horizontal coordination with other sectors including social services, education and justice. Beyond this, existing horizontal coalitions were found in only two other contexts: (1) between regional service providers; and (2) in educational directives in which schools are mandated to collaborate with health and social services providers (MB/ME, 2018; 2022).

Furthermore, in investigating the types of coordination in the Manitoban policy subsystem of MHSUD, only symbolic policies (Virgo Planning, 2018; MB/MMHCW, 2022) take on policy integration, in which high level policies are designed to work in tandem with each other. The Virgo Report deemed "jurisdictional issues a fundamental challenge" (p. 46) in the Manitoba, resulting in a lack of material cross-sector policy integration examples. Policy coordination relationships based in service coordination are more common. For example, the MB/MMHCW's funding partnership with the United Way (Government of Manitoba, 2022d) is not built on a shared policy vision between MB/MHHLS and the MB/MF, but rather a funding partnership which bypasses the MB/MF in providing social supports.

Another material service coordination action is of note is a 2019 co-implemented pilot project in Brandon, Portage la Prairie, and Steinbach schools along with regional health authorities and Addictions Foundation of Manitoba. This project, funded by MB/ME and MB/MHHLS, provides psychiatric nurses in rural school divisions as mental health and addiction nurses (Government of Manitoba, 2019). This policy action demonstrates how, in lieu

of over-arching provincial structures and plans, governmental supports and services may become inequitably distributed in different jurisdictions. While this policy action has promise as a cross-sector strategy to add additional supports to the school system itself, there does not seem to be any provincial directives with regards to sustainability or scalability. Furthermore, this policy action comes after the Virgo Report (2018), and before the establishment of the MB/MMHCW (2021) or the *Pathway to Mental Health and Community Wellness* document (MB/MMHCW, 2022). Yet there is no mention of these types of school-based supports in any of the provincial strategic planning documents by MB/MMHCW, which suggests a lack of collaboration with regards to strategic planning and policy actions. Additionally, following the 2019 press release outlining this policy action and the relevant RHA's postings to hire psychiatric nurses, the initiative is not mentioned again provincially in any policy documentation, which suggests a "one and done" mentality where this initiative is not tied to additional strategies. Instead, the initiative is mentioned in a smattering of media-based contexts by school divisions and RHAs without being tied to any provincial framework for service delivery.

Given calls for a "a very comprehensive plan on the implementation of mental health services across the province" (Manitoba Advocate for Children and Youth, 2020), RHA responses tend instead to provide examples of asynchronous actions without a cohesive planning structure. Further, there seems to be a trend in policy actions related to MHSUD in Manitoba in which press-releases, intended to spawn media coverage and political attention, are driving forces to policy action in which pilot projects with media fanfare are not co-implemented with strategic without the presence of these funding commitments or policy actions in actual strategic planning, policy directive, or policy position papers. MHSUD funding announcements (Government of Manitoba 2019, 2022c, 2022d) are plentiful, but as will be discussed below, the

actual strategic planning document itself for the province has a shortage of actionable objectives and strategies which can be tracked to monitor progress.

Within vertical coordination models, catalysts to coordination such as shared visions, presence of policy actors in planning, accountability mechanisms for fidelity are common. This is owed to the fact that the siloed, self-sufficient provincial ministries have over time developed strong coordination and accountability mechanisms for governance and service delivery. A key example of vertical coordination to support the discourse of intent of cross-sector approaches to MHSUD is Manitoba's, *Health System Transformation* (2022) plan. This plan, born out of recommendations in the Virgo Report (2018) and following the vision of *Pathway to Mental Health and Community Wellness* (2022), includes a strategic plan, shared planning across geographical regions, and stakeholders in the health care community via a designated leadership team and clear markers of success to ensure fidelity of implementation at all levels of health governance (MB/MHHLS, 2023). Funding to regional health programs, including prevention, harm reduction, and outreach teams for MHSUD (MB/MMHCW, 2022b) suggests that funding pathways for these health initiatives have been developed in response to grass-roots data (MB/MHHLS, 2022).

However, when it comes to horizontal coordination mechanisms, there are numerous barriers. For example, provincial strategic planning documents acknowledge that existing systems plan "health services in relative isolation from one another, leading to duplicate services and inefficient service delivery while acting as an impediment to the development and implementation of a clinical services plan for all Manitobans" (MB/MMHCW, 2022, p. 9). However, neither the Virgo Report (2018) nor the *Pathway to Mental Health and Community Wellness* (2022) documents have included stakeholders from education or social services sector

at the planning or information gathering stage. In the Virgo Planning document (2018), only financial data from the education sector is included in framing the policy problem itself, suggesting that while education sector is cited as a potential policy partner, the actual implementation of or need for MHSUD supports in schools has not informed policy directions. Furthermore, the citation of the financial data in the Virgo Report is problematic in itself as it identifies a fixed amount of funding that is devoted to MHSUD in education provincially. This occurs without any data on the funding and resources that are assigned to MHSUD supports at the regional levels, or within school-based funding decisions, due to a lack of collaboration with education at the data-collection stage. The Virgo Report does cite "the need for collaboration between post-secondary schools and local services, given the high [mental health] needs among student bodies" (2018, p. 48). However, despite this, the provincial plan for MHSUD in the *Pathway to Mental Health and Community Wellness* (2022) document alludes to intentions to forge partnerships with education but without educational or social services partners as a part of the development of the document.

Additionally, in terms of existing accountability mechanisms for fidelity of implementation as a catalyst to coordination, Manitoba's *Pathway* document (MB/MMHCW, 2022) is notably devoid of material outcomes and cross-sector strategies. For example, the *Pathway* document pledges to "work across sectors and levels of government" and plans to "support and enable all policy and government partners" (2022, p. 9). However the strategies outlined to enhance collaboration include designing essential core services, developing integrated models of care with education, social services and justice, increase supports for clients and collaboration with other departments. Though ministry document advocates for collaborative approaches, these are not represented in service providers or websites guiding public to resources

(MB/MMHCW, 2023a). Social services, education, and justice sectors are mentioned as partners, however, these stakeholders were not included at data collections stage and so roles moving forward are vague: "We *will* work with education and social services…" [emphasis added] (MB/MMHCW, 2022, p. 14) without any tangible outcome.

Coordination and collaboration with Indigenous communities and the TRC Calls to Action. There are commitments to inclusion of Indigenous perspectives across all discourses of intent in the Manitoban provincial context. Nevertheless, these commitments tend to be symbolic in nature, and often do not include Indigenous communities in planning stages or include a shared vision with Indigenous groups. The MB/MMHCW and Community wellness both include verbal commitments to engage with Indigenous perspectives for service provision, but evidence of actual collaboration is not seen at the provincial level. Based on this document analysis, the Assembly of Manitoba Chiefs' primary means for advocating for service provision for Indigenous peoples in Manitoba is through their partnership with a federal initiative, namely, Jordan's Principle. That is, there is no evidence of provincial-level material policy coordination in the policy subsystem of MHSUD with Indigenous governance in Manitoba beyond funding partnerships with Jordan's Principle.

Key takeaways: Manitoban data set. In the Manitoban data set, there are some key takeaways regarding MHSUD policy in this subsystem. First, the move to socio-ecological understandings of health to inform cross-sector MHSUD responses is a recent development in the Manitoban provincial subsystem. However, as with the federal data set, this understanding of MHSUD is primarily seen in symbolic policies and is not well supported by material policies (action). At the provincial level, material policy actions are generally supported by single-sector policy initiatives rooted in discourses of intent that align with traditional ministerial mandates.

Furthermore, though there has been a clear mandate laid out by the Virgo Report (2018) to develop a tiered continuum of cross-sector MHSUD supports, the strategic planning document by MB/ MMHCW (2022) is notably void of material policy directives, mandates, strategies, and measurable outcomes, especially for MB/MF and MB/ME who are mentioned as "partners" without clear pathways forward. This is perhaps due to the timing of both the creation of the MB/MMHCW and the undertaking of the Health Care Transformation concurrently, which has resulted in a conflation of health care restructuring with a MHSUD mandate. In the wake of both of these initiatives, it is not clear if strategies such as consolidating access points, creating mobile mental health teams, the dissolving of MB/AFM and the creation of Shared Health as a provincial driver for MHSUD service are strategies in support of increased service provision for MHSUD or in service of health care restructuring. Furthermore, in a system in which there tends to be strong path dependence within traditional ministerial mandates, the elimination of the MB/HCMO means an elimination of all cross-sector offices looking at the needs of youth. In terms of policy learning, this removes a valuable opportunity for cross-sector collaboration and information sharing, which could move foreward more developed conceptualizations of a policy problem.

Provincial Stakeholders: British Columbia

In the British Columbian provincial context, 21 documents were reviewed from the following provincial policy actors:

- Ministry of Mental Health and Addictions (BC/MMHA)
- Ministry of Health (BC/MH)
- Ministry of Education and Childcare (BC/MECC)
- Ministry of Child and Family Development (BC/MCFD)
- Select Standing Committee on Children and Youth (BC/SSCCY)
- British Columbia Assembly of First Nations (BC/AFN)

Discourses of intent: What are the stakeholders' interests and beliefs? Using the same process for coding for signifiers and identifying discourses of intent as used above, at the provincial level in British Columbia, six discourses of intent were identified:

1. Treatment of **MHSUD as a cross-sector issue** with intent to minimize harms;
2. Administration of **service provision for MHSUD;**
3. Treatment of **MHSUD as a social issue**;
4. Establishment of **safe schools**;
5. **Primary prevention** programming; and
6. Treatment of MHSUD as a **public biomedical health** issue.

Table 5.10 outlines the key discourses of intent, and examples of the discourses of MHSUD which were used to support each discourse of intent.

Table 5.10 Discourses of Intent and Discourses for MHSUD in Provincial (BC) Examined Documents

Dominant Discourse-of-Intent	Time-frame	Stakeholders Represented	Examples of Stakeholder Interests Supporting the Discourse-of-Intent	Discourses of Stakeholder MHSUD Beliefs Supporting Discourses of Intent
Minimize harms from MHSUD by treatment as a cross-sector issue. *PBC4, PBC5, PBC9, PBC10, PBC19, PBC20, PI2*	2018 - 2021	MHA CFD MH SSCCY	• Develop a "pathway to wellbeing for all" (MHA 2019, p.2) with "improved mental health and wellness for children, youth and young adults" (MHA, 2021, p. 7) • "transforming mental health and substance use care.[marked by] improved wellness" (MHA, 2021, p. 4) • reduce impacts of MHSUD and implement a sustainability of supports (MH & CFD, 2010) • formal position re:family-centered MHSUD care (CFD, 2015) • policy framework for inclusion of Indigenous perspectives and knowledges in care systems with children (CFD • provision of culturally relevant mental health supports as part of reconciliation (BFAFN, 2020) • "reduce the consequences of mental illness in our youth population" (SSCCY, 2016, p.iv). • "Working in collaboration with the Government of Canada, First Nations Health Council, and FNHA to support funding for community-driven, Nation-based approaches to the social determinants of mental health and wellness" (MH, 2022, p. 6)	**Socio-ecological Health Issue** • Like physical health, "mental health and wellness is something that can change over time" (MHA, 2019, p. 2) and is influenced by relationships, environment and physical health. • encompasses physical, spiritual, mental and emotional wellbeing (MHA, 2021, p. 4) • situated in an individual, but must by viewed as part of the context of their family, culture and community (CFD, 2015) • Mental health as linked to cultural identity and services rooted in culturally competent care (CFD, year) • "essential to physical health, personal wellbeing and positive family and interpersonal relationships" (MH & CFD, 2010, p. 5) • Mental health and problematic substance use (MH & CFD, 2010). • Importance of Indigenous understandings of wellbeing in contradistinction to wester ideas (BCAFN, 2020) **Economic Issue** • Improve MH services...to reduce…its impact on the economy and society" (SSCCY, 2016, p. iv)
Service Provision for MHSUD *PBC2, PBC3, PBC8, PBC11, PBC16-18*	*2013 - 2023*	MHA CFD	• Mental health and wellness services for youth (MMHA, 2021, p. 3) • "support for substance use problems and addiction recovery" (MHA, 2023) • Administration of child and youth mental health teams and clinical services for youth MHSUD (CFD, 2019, p. 4)	**Public Health Issue** • Mental health as linked to wellness (MMHA, 2023 • mental health listed as a universally accessible support–addiction only listed in connection with intensive /emergency supports **Socio-ecological Health Issue** • Mental health challenges and disorders that impact their ability to function across a variety of settings and situations • "substance problem"; harm is caused to self/ others (MHA, 2023)
Safe Schools *PBC12, PBC14*	1996-2023	ME	• Mandate to and guidelines for developing codes of conducts in schools	• No overt mention of MHSUD; provision that disciplinary consequences take into account the "consider development of student" (ME, 2016, p.7)
Primary Prevention *PBC13*	2020	ME	• "positive mental health promotion" the job of schools; "create school environments that support student wellbeing and positive mental health: (ME, 2020, p.3)	**Socio-ecological Health Issue** • Positive mental health as a marker of wellbeing **Public Health Issue** • Positive mental health as a means to preventing serious mental illness (RTI model)
Treatment of MHSUD as a Public Health Issue *PBC1, PBC6- 7*	1996-2023	MH	• Procedures for voluntary and involuntary mental health admissions • Licences, permits, health officials and legislation of health care system	**Public Health Issue** • Mental health/disorders listed alongside physical health as a service mandate
Treatment of MHSUD as a Social Issue *PBC15*	1996-2023	CFD	• Support safety and wellbeing	**Socio-ecological Health Issue** • Safety and wellbeing • Mental health services, addiction services (separate)

Minimizing harms by treatment of MHSUD as a cross-sector issue was a dominant discourse of intent in eight examined documents, including documents from Ministry of Mental Health and Addiction (BC/MMHA), Child and Family Development (BC/CFD), Ministry of Health (BC/MH), Select Standing Committee on Children and Youth (BC/SSCCY) and British Columbia Assembly of First Nations (BC/AFN). Documents in this data set were coded with intents such as developing a "pathway to wellbeing for all" (MHA 2019, p. 2) with "improved mental health and wellness for children, youth and young adults" (MHA, 2021, p. 7) and provision of culturally relevant mental health supports as part of reconciliation (BC/AFN, 2020). This discourse of intent was supported by characterizations of MHSUD as a symptom of ecological health; as influenced by relationships, environment, and physical health (BC/MMHA, 2019, p. 2); as linked to cultural identity (BC/MCFD, 2015); and as "essential to... personal wellbeing" (BC/MH & BC/MCFD, 2010, p. 5).

Service provision for MHSUD was a dominant discourse of intent in seven examined documents, from BC/MMHA and BC/MCFD. Documented intents included providing "support for substance use problems and addiction recovery" (BC/MMHA, 2023), administration of child and youth mental health teams, and clinical services for youth MHSUD (BC/MCFD, 2019, p. 4). In this discourse of intent, MHSUD was framed as a biomedical health issue and a socio-ecological health issue. For example, by identifying mental health listed as a requiring health care supports including universal supports and intensive/emergency supports, and as a challenge that can impact ability to function across a variety of settings and situations and by defining a "substance problem"—when harm is caused to self or others (BC/MMHA, 2023).

Discourses of intent of safe schools (dominant discourse of intent in two policy documents) and primary prevention programs (dominant discourse of intent in one policy

document) were solely supported by the BC/MECC. In the safe schools discourse of intent, MHSUD is only mentioned peripherally as a behaviour that would warrant the code of conduct to be invoked with potential disciplinary action. In the discourse of intent of primary prevention, MHSUD was presented as an issue of harms with positive mental health as a marker of wellbeing, "embedded in all aspects of the education system, including culture, leadership, curriculum and learning environments" (BC/MECC, 2020, p. 14). Mental-health promotion was framed here as a system-wide goal working to improve wellness and reduce harms, with positive mental health as a means to preventing more serious mental illness.

Provision of health care was a dominant discourse in three documents from BC/MH and provision of social supports was a dominant discourse of intent in one document, supported by BC/MCFD. In these discourses of intent MHSUD was characterized as a health issue—where mental health listed alongside physical health as a service mandate (BC/MH, 1996) and an issue of harms—where safety and wellbeing were cited as positive outcomes (BC/MCFD, 2023)—respectively.

Themes related to discourses of intent and discourses of MHSUD. The two most dominant discourses of intent (harm reduction via cross sector frameworks and administering [cross sector] service provision) are aligned in their attempt to adopt cross-sector approaches and cross-ministerial responses to MHSUD in the form of cross-sector strategic plans and service delivery frameworks, respectively. These cross-sector discourses of intent are both supported by a variety of stakeholders across ministerial units including BC/MCFD, BC/MMHA, BC/MECC. Within these cross-sector discourses of intent, beliefs of MHSUD rooted in health and harms were more common in the service provision discourse of intent. These acknowledged harms causing any type of multi-faceted problem for individuals or their relationships (BC/MMHA,

2023) and provision of child and youth supports and services for youth MHSUD (BC/MCFD, 2019). Alternately, strategic plans and birds-eye documents (such as BC/MMHA, 2018; BC/MMHA, 2020; BC/MCFD, 2015) framed with system-wide goals, contained iterations of MHSUD rooted in broader socio-ecological contexts. For example, MHSUD as linked to cultural identity and services rooted in culturally competent care (BC/MCFD, 2015) was noted in the BC data set. MHSUD was positioned as "situated in an individual, but… as part of the context of their family, culture and community" (BC/MCFD, 2015, p. 4), and MHSUD focused on rectifying past "neglect of promotion, prevention and early intervention services [which contributed] to a downward trend in the social and emotional development of" children (BC/MMHA, 2019, p. 2).

In the BC data set, discourses of intent stemming out of a single sector were less common than multi-sector, multifaceted response paradigms. For example, solely health-sector responses to MHSUD were seen in only three documents. Primary prevention for MHSUD as a dominant discourse was only utilized in policy related to schools (BC/MECC, 2020) and discourses of safety were only seen in documents dealing with social supports and education (BC/MECC, 2016; BC/MCFD, 2019). In the BC policy landscape, 14 documents' discourses of intent were cross-sector in nature, representing multiple policy actors. Only seven were supporting discourses of intent that were single sector in nature and supported by a single ministry, which suggests that cross-sector integration may be more entrenched in this jurisdiction.

Varied discourses between stakeholders and changes over time. Stemming out of key cross-sectoral recommendations in the BC/SSCCY 2016 report on youth MHSUD and the subsequent development of the BC/MMHA and its *Pathway to Hope* (2018) document, there is evidence of policy overhauls and changes to discourses in a number of sectors related to youth

MHSUD. *The Mental Health Strategy in Schools* (BC/MECC, 2020) and the *Child and Youth Mental Health Service Framework* (BC/MCFD, 2019) both take on cross-sector responses to MHSUD building on the *Pathway to Hope* document and rooted in understandings of socio-ecological health and holistic service delivery frameworks. For example, the assertion that MHSUD responses must include physical, spiritual, social, mental, cultural, and emotional wellbeing (BC/MMHA, 2021, p. 4). Purposeful and direct discussions of mental health as linked to cultural identity (BC/MCFD, 2018, 2021) in partner policy documents represent a cross-sector understanding of a socio-ecological health perspective.

The discourse of intent of responses to MHSUD rooted in a socio-ecological model of health is a departure from the previous provincial plan for MHSUD, 2010's *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia*. This past plan was still cross-sector in nature, being co-implemented by BC/MH and BC/MCFD, but was rooted predominantly in discourses of health care provision and an emphasis on family health-related harms (drawn out of Canada's [2003] *Child and Youth Plan*). While this strategic plan led to updates in BC/MCFD and BC/MH policy, discourses centre around MHSUD as a health phenomenon (BC/MH & BC/MCFD, 2010) and a familial problem rather than a broader social one. For example, it was framed as "essential to physical health, personal wellbeing and positive family and interpersonal relationships" (BC/MH & BC/MCFD, 2010, p. 5). This change in discourses over time was similar to the federal Stakeholder Analysis, which also showed a shift in discourses from understandings of MHSUD as a health-based issue to understandings of MHSUD as rooted in understandings of socio-ecological health and harms.

However, alongside this shift in how MHSUD was conceptualized in the BC policy subsystem, policy documentation also shows that policy actions related to MHSUD are being

justified from a financial lens. BC/MMHA and BC/ME both, in their strategic planning documents, make connections to fiscal responsibility. For example, "for every dollar spent on evidence-based addictions treatment, the taxpayer saves $12 in health and social costs" (BC/MMHA, 2019, p. 5); and that "if the number of people experiencing a new mental illness in a given year was reduced by 10%, after 10 years, we would be directing more than $4 billion a year into other services" (BC/MECC, 2020, p. 12). This suggests that the discourse of intent socio-ecological health provision may not have enough sway in and of itself to justify large-scale policy actions and that there is still stigma related to MHSUD supports in public policy.

Discourses of action: **BC data set**. Provincial policy actions in BC take the form of legislation, position papers, strategic plans, funding agreements, service provision arrangements, ministerial directives and service delivery frameworks. Table 5.10 outlines the policy actions associated with discourses of intent, organized by policy actor. As with past stakeholder groups, I break down policy actions into material and symbolic policy actions and I also investigate policy actions as storylines of control or decline in order to understand policy actor positioning.

***Symbolic and material policy actions*.** As demonstrated in Table 5.11, the majority of policy actions in the BC policy subsystem of MHSUD are material in nature, in keeping with the federal delegation of the matter to provinces. Some key symbolic policies. *Planning for Hope* (BC/MMHA, 2018); *Families at the Center* (BC/MCFD, 2015); *Aboriginal Policy and Practice Framework* (BC/MCFD, 2015)) lay out strategic plans and service delivery frameworks. In general, these symbolic policy actions are paired with material policy actions stemming out of the strategic recommendations at different tiers of intervention. For example, BC/MMHA (2018) calls for Integrated Child/Youth Teams (ICYT) in schools which is supported by material policies which were subsequently implemented by BC/MCFD (2022) and BC/MMHA (2022).

Table 5.11
Policy Actions Associated with Discourses of Intent in Provincial (BC) Documents

British Columbia Discourses of Intent	Policy Actor Supporting Discourse-of-Intent	Policy Actions Associated with Discourses of Intent	
		Material Policy Actions	**Symbolic Policy Actions**
Minimize harms from MHSUD by treatment as a cross-sector issue *PBC4, PBC5, PBC9, PBC10, PBC19, PBC20, PBC21*	**Ministry of Mental Health and Addictions**	3-year plan embedded in the larger strategic plan *Pathway to Hope* lays out material policy actions, including: • Tiered MHSUD programming in schools, increased across sector tier-3 supports • Integrated Child/Youth Teams in Schools, Expansion of virtual, preventative, First Nations health care • Declaration of Commitment to Cultural Safety and Humility	• Priority actions for MHSUD in BC: improved wellness; supporting Indigenous-led solutions; better care and access • Review policy mandates to provide MHSUD "care…. to reach them where they are – in their homes, communities and schools" (p.7). • Plan to engage with community partners to support youth MHSUD care
	Child and Family Development	• None identified	• Policy framework "to improve outcomes for [Indigenous] children, youth, families and communities through restorative practices and policies" (p. 12) • "helping systems and their representatives to make a cultural shift that embraces a family-centered approach to policy and practice" (p. 7)
	Select Standing Committee on Children and Youth	• Expansion of community capacity to reduce demand on emergency rooms and better meet needs of youth • Increased 2SLGBTQ and Indigenous workshops to develop practices that increase inclusion • Improve legislation on information sharing between service providers and sectors.	Recommendations to Province of BC regarding: • Leadership, accountability for MHSUD and the recommendation for form a new ministry of MHSUD to improve cross-sectoral delivery of services • Integration and delivery of services via cross-sectoral pathway and mandate for MHSUD services utilizing co-location of services • Expansion in types of services offered youth via: one child, one file; triage timelines, MHSUD programs in schools and community, improved continuum of supports.
	BCAFN	• None identified	• Policy paper outlining indigenous understandings of wellness
Service Provision for MHSUD *PBC2, PBC3, PBC8, PBC11, PBC16-18*	**Mental Health and Addictions**	• Provision of overdose prevention programs, recovery services and treatment supports, including phone, email, chat and online supports • Free mental health and wellness services for Indigenous children	• None identified
	Ministry of Health	• Funding of and direction to organizations supporting service provision for MHSUD locally	• None identified
	First Nations Health Authority	• MHSUD funding for local Indigenous programming including cultural activities, treatments, substitution therapies, harm reduction strategies, crisis lines, virtual supports, treatment centers, suicide prevention	• None identified
	PHA	• Collation of service provision access points for MHSUD provincially	• None identified
	Child and Family Development	• Provision of "voluntary, evidence-informed mental health services…[for] mental health challenges…that significantly impact ability to function across a variety of settings and situations." (p. 20) with a service framework	• None identified
Social Issue *PBC15*	**CFD**	• Legislation to support safety and wellbeing of children including provision of MH services	• None identified
Safe Schools *PBC12, 14*	**Ministry of Education**	• Mandate that all schools have code of conduct • Directive regarding what all codes of conduct must include	• None identified
Prevention *PBC13*	**Ministry of Education**	• Staffing and curriculum to support: social emotional learning, mental health and trauma-informed practice.	• Guidelines to embed wellbeing and Indigenous knowledges: social emotional learning, mental health and trauma-informed practice.
Public Health Issue *PBC1, PBC6-7*	**Ministry of Health**	• Outline admissions criteria for requiring hospitalization for MH • Administration of licenses, permits, health regulations and officials • Legislation for funding and administration of Ministry of Health in BC	• None identified

In addition, BC/MCFD provides targeted youth mental health therapy and supports in a dual mandate serving youth in care, but also via a mandate to direct mental health service provision for all BC youth. The BC/MECC employs a preventative curriculum and also directs MHSUD staffing supports in schools to implement this primary prevention strategy. That is, there is a clear line from symbolic declarations to material policy actions—in service of socio-ecological models of health, and across ministries— which was not seen in the Manitoban data set. However, this collection of policy responses from different sectors in pursuit of a common goal has the potential to result in a lack of clarity with regards to where these distinct material actions begin and end. This is because BC/MH's ICYTs, BC/MCFD mental health supports, and BC/MECC's preventative and student support services are all mandated to support youth at the same time.

Despite the entrenchment of ministerial units in the federalist system, and the policy actions unique to those ministerial units, numerous material policy actions are cross-sector in nature in the BC policy subsystem of MHSUD. This appears to be a case in which there has been concerted effort to combat isomorphism common in Canadian federalism whereby ministerial sectors are more likely to plan internally than collaboratively (DiMaggio & Powell, 1983). Policy actions in support of the 2018 *Planning for Hope* refer tiered actions to independent ministries centred around providing a single continuum of care. These policy actions range from "promotion of social emotional health" in schools, to supporting mental health services (p. 19) in schools, to partnering with NGOs to ensure more service provision options, and to an increase in strategies to prompt in-patient or intensive services responses (2018, p. 19).

With an acknowledgment that

> The challenge facing us in moving forward is addressing persistent fragmentation. By delivering more person-centered services, the continuum of mental health promotion, prevention, treatment and recovery services becomes more effective and efficient and, more importantly, is built around the needs of the individual. (MMHA, 2018, p. 6)

Throughout policy documents, there is a focus on tiered care, or "stepped care" as it is referred to in the BC subsystem, with an intent of aligning service intensity with need, using more specialized services to address higher level needs (BC/SSCCY, 2016). Though there is evidence of cross-sector policy actions, there is also an acknowledgement of a lack of tiered programs, particularly for marginalized groups (BC/SSCCY, 2016).

Action-based discourses in relation to schools. The strategy for response to socio-emotional/behavioural concerns in schools previous to BC/MECC's 2020, *Mental Health Strategy in Schools,* was the *Safe and Orderly Schools Strategy*, "designed to help make schools places where students are free from harm, where clear expectations of acceptable behaviour are held and met, and where all members of the school community feel they belong" (2004, p. 4). This strategy boiled down to ideas of wellness as rooted in physical safety and responses to bullying, noting that, "violence among children and youth is a complex social problem best addressed through local solutions" (MECC, 2004, p. 7). MHSUD was not overtly named in this strategy document, except for discussions of substance use in the Code of Conduct—denotating disciplinary responses.

The Mental Health in Schools Strategy is intended to be "a whole school system that promotes positive mental health… embedded in all aspects of the education system, including culture, leadership, curriculum and learning environments" (2020, p. 8). This primary-prevention program positions schools as first contact and established community institutions to provide

MHSUD programming including education, skill-building, and supportive systems in response to MHSUD concerns in youth. This preventative strategy is couched within a curricular framework with key goals of collaborative dialogue, pedagogy of listening, pedagogical narration, and critical reflection (ME, 2020). There is an acknowledgement that "environments are integral to wellbeing and learning" (p. 1), and therefore, school counsellors, psychologists, and other staff are employed to support specialized MHSUD supports in the school (BC/MECC, 2023).

Existing BC/MCFD MHSUD supports for children and youth (BC/MCFD, 2019) include therapeutic supports, counselling, and skill-building resources for youth. Added to this are newly developed, *Integrated Child and Youth Teams* (BC/MMHA, 2021), which are teams of MHSUD professionals who work with youth in schools as focal points of community access (BC/MH, 2023). This growth in supports demonstrates that there is some attention paid to providing points of access to MHSUD supports at all tiers within the school system itself, and that funding for this access is spread across ministries, rather than residing solely with education. In fact, in the BC/MMHA 2018, *Planning for Hope*, it is noteworthy that health care initiatives—such as naloxone and overdose treatment plans with hospital and health implications—are covered last in the provincial plan of action, after discussions of community-based and school-based tier one supports (for example, fulsome MHSUD education programming).

BC discourses of coordination. Much like Manitoba's 2018 *Virgo Report*, British Columbia's 2019 strategic plan document for BC/MMHA, found that MHSUD care in BC was a "patchwork of services, [with an] inconsistent way they are delivered and disconnected from each other" (BC/MMHA, 2018, p. 3). The resulting plan, policy actions, and reporting document were intended to increase coordination and improve service delivery. Table 5.12 shows the existing coalitions demonstrated in the BC provincial data set for this Stakeholder Analysis, the

type of coordination being employed (vertical or horizontal), the level of coordination (service coordination or policy integration) and the barriers and catalysts to improved coordination.

Table 5.12 Coalitions, Types of Coordination and Barriers to Coordination in Provincial (BC) Documents

Discourses of Intent *Document codes supporting this discourse*	**Policy Actor Supporting this Discourse - of-Intent**	**Coalitions – existing partnerships with policy actors** **(By Policy actors)**	**Opportunities or Barriers to coordination** **(By policy actor)**		
			Evidence of Vertical or Horizontal Coordination	**Low level service coordination or policy integration**	**Opportunities and Barriers:** • **Shared Values/Lack of Shared Values (SV/LSV)** • **All Policy Actors Present (APAP)/ Not Present (PANP)** • **Fidelity Implementation (FOI)/ Lack of Fidelity (LFI)** • **Funding Decisions at Same Level (FDSL)/ Different Levels (FDDL)**
Minimize harms from MHSUD by treatment as a cross-sector issue. *PBC4, PBC5, PBC9, PBC10, PBC19, PBC20, PBC21*	**Ministry of Mental Health and Addictions**	**Federal** • CMHA • Chief Public Health Officer **Provincial** • Rep. for Children and Youth • Auditor General • Doctors of BC • First Nations Health Authority • BC Psychological Association • Ministry of Health • Ministry of Education • Child Health BC • Ministry CFD • Prenatal Substance Use Program • First Nations Health Council • First Nations Health Directors • BC Drug and Alcohol Information and Referral Service • Partners for Mental Health and Addiction **Regional** • Local service providers • School Divisions • First Nations • Regional Health Authorities	Vertical (federal-provincial – directives and mandates; provincial – local service provision) and Horizontal (cross-provincial)	Policy Integration – service delivery options follow provincial mandates and ground-level coordination unlikely as provincial level coordination in place	SV, FDSL • Shared priority actions orchestrated by MHA with all policy actors at the table – "across ministries, with Indigenous partners and service delivery partners [to] build a culturally safe and effective system of care" (MHA, 2018, p. 9) • Outcomes and priority actions including key actions for mental health in schools including integrated child and youth treatment teams • CFD runs and funds youth mental health services, health runs School based multi-disciplinary teams APAP • *Mental Health in Schools Strategy* is rooted in Pathway to Hope and vice-versa – guiding documents speak to each other and are in line with CFD service delivery framework. • Integrated youth teams in schools support multi-tiered interventions in schools and cross-supported by health, education, CFD • Noteworthy that health care initiatives are covered LAST in the provincial documentation – naloxone, overdose treatments all fall after discussions of educational and social tier 1 and 2 supports. • MOU with regards to Indigenous perspectives places these perspective throughout programming models FOI • Co-Planning with Indigenous communities and increased funding to Indigenous initiatives • Bring services and supports to families and caregivers • 3-year plan with defined actionable items across sectors PANP • ICYMH Teams run by health in schools, not education.
	Ministry of Child and Family Development	**Provincial** • Ministries of Health, Education **Regional** • Reginal Health Authorities • Service Providers	Vertical – policy framework directive	Service Coordination	PANP • Policy frameworks prioritizing Indigenous and family-based approaches to wellness are specific to CFD and are not cross-sector in nature SV • CFD – establishment of guiding principles
	Select Standing Committee on Children and Youth	**Provincial** • Cross-partisan members of ministries of Health, Education, CFD • Representative for Children and Youth • Community Consultations	Horizontal	Policy Integration	PAP, SV • Cross-partisan representatives from independent ministries in child-serving systems to respond to RCY recommendations and make recommendations to their own ministries with the shared vision of supporting youth past partisan allyship. FOI • Recommendations influence by reports and ground-level inquiries with specialists, universities, the public.

	BC Assembly of First Nations	**Federal** • Wellbeing indexes **Provincial** • Provincial governments	Horizontal	Policy Coordination	PANP, LSV • Call for equal footing of Indigenous understandings of wellbeing to be considered in policy actions • Wellbeing as an alternative to GDP as a measurement of success
Service Provision for MHSUD *PBC2, PBC3, PBC8, PBC11, PBC16-18*	**Ministry of Mental Health and Addictions**	**Provincial** • First Nations Health Authority • Health Links • BC Partners for Mental health and Addiction • BC Information and Referral Service **Regional** • Regional/Local Service Providers	Vertical – referral to regional service provision	Service Coordination and Provision	SV • Strategic plan a singular provincial strategy with multi-sector action plans PAP • CYMH teams refer to youth mental health services and Indigenous mental health services – all overseen and implemented provincially FOI • multiple access points across ministries, programs report to ministries • Indigenous partners part of strategic plan and outcomes reports • Step-up/Step-down beds responsive to individuals
	Ministry of Health	**Provincial** • Child and Family Development • Anxiety Disorders Association • First Nations Health Authority **Regional** • Regional Health Authorities • Service Providers	Vertical – referral to service provision.	Service Coordination and Provision	FOI • Listing of all services
	Ministry of Child and Family Development	**Provincial** • BC Ministry of Health **Regional** • Service providers	Vertical and horizontal (CFD and Health)	Service coordination	• While ministries of health and mental health develop service provision for MH, CFD oversees their own service framework for youth • CFD aims to support child and youth mental health teams that are community based (utilizing local resources) and culturally safe
Treatment of MHSUD as. A Social Issue *PBC15*	**Child and Family Development**	None identified	Vertical	none	FOI • Directive to agencies supporting youth in care or youth at risk
Safe Schools *PBC12, PBC14*	**Ministry of Education**	**Regional** • Reference to outside service providers	Vertical	none	FOI • Directive for administration of schools • Directive for development of Code of Conduct
Primary Prevention *PBC13*	**Ministry of Education**	**Federal** • MHCC **Provincial** • MMHA **Regional** • School divisions	Horizontal	Policy Integration	• This preventative plan. Is implemented alongside MHA, MH and CFD strategies for youth MH supports • Tiered plan • Not overt – this document does not reference higher tiersteams
Treatment of MHSUD as a Public Health Issue *PBC1, PBC6- 7*	**Ministry of Health**	**Federal** • Government of Canada **Provincial** • Health Authorities	Vertical	none	• Pure vertical directives and legislation – single sector for health administration; not cross-sector.

The analysis demonstrated that the majority of coordination efforts at the provincial level of the policy subsystem were vertical in nature—by virtue of provincial ministerial legislation laying down programmatic expectations for regional service providers (BC/MCFD, 2019; BC/MH, 2022, BC/MMHA, 2019). The analysis also showed that the BC/MMHA has taken on substantial horizontal coordination with BC/MECC, BC/MH and BC/MCFD, along with First Nations and NGOs with an attempt to establish a robust cross-sector MHSUD policy integration framework. The previous strategic plan on MHSUD, *Healthy Minds, Healthy People* (2010), co-implemented by BC/MH and BC/MCFD, showed evidence of a population health approach including emphasis on tiered interventions based on harms, defined as "personal suffering and interference with life goals" (BC/MH & BC/MCFD, 2010, p. 11). However, this 2010 document served primarily to emphasize the efforts made since Canada's 2003 *Comprehensive Child and Youth Plan* and showed more evidence of vertical service-direction than horizontal partnership by citing research direction in a tiered system. The 2010 strategic plan exhibited coalitions with university leadership, provincial health services, NGOs, and federal directives from the MHCC and the JCSH, which were vertical in nature.

There is strong evidence of a shared vision and fidelity of implementation in the BC/MMHA strategic plan. The document includes a three-year priority action framework, and pre-planned reporting timelines for that framework. Furthermore, the policy review shows collaboration with Indigenous groups. That includes a tripartite memorandum of understanding between Canada, BC and the BC First Nations Health Council; a First Nations Health Authority Declaration of Commitment to Cultural Safety and Humility; expansion of Expand First Nations-run treatment services; and First Nations primary health care initiatives, as well as increased collaboration with service provision via NGOs. For example, expansion of Foundry Centers

province-wide and increased service provision for MHSUD through the Ministry of Health and BC/MCFD. This included core programming in child development centers, focused programming for youth aged 3-12 with social-emotional deficits, expansion of virtual counselling, and the addition of Step-up/Step-down beds (BC/MMHA, 2021). As an indicator of actual policy integration, policy directives consistent with the strategic plan from BC/MMHA are seen in specific policy documents from education (BC/MECC, 2021), health (BC/MH, 2023), and BC/MCFD (2019).

It is noteworthy that the 2018 *Pathway to Hope's* evidence of horizontal collaboration draws heavily on the 2016 report by the BC/SSCCY's titled, *Final Report on Child and Youth Mental Health in British Columbia*. This BC/SSCCY is itself an exemplar for a successful catalyst to meaningful policy integration. This standing committee was originally formed to receive and review annual service plans and reports from the Representative for Children and Youth (RCY) and to complete investigations, where deemed necessary, following these reports to ensure that children's needs are met (BC/SSCCY, 2016, p. iii). The standing committee was purposely formed as a cross-partisan entity with involvement from both the governing party and the official opposition and with representation across child-serving ministries. In this way, the intent was to consider youth needs above partisan politics and ministerial limitations. As a working group, BC/SSCCY took on the work of both rallying for, and considering possibilities for models of integrated service delivery, finding that in the existing system there was fracturing between BC/MCFD care plans and MH plans with the acknowledgement that an integrated system could not be facilitated only through a medical model of care. As one stakeholder put it, care in the "hospital is under the Ministry of Health… in the community, [youth are] under BC/MCFD, so different mandates, different standards, different philosophies of care, different

systems, different computer platforms" (BC/SSCCY, 2016, p. 12). Thus, the recommendation to form a singular ministry of BC/MMHA with an integrated service delivery model includes recommendations for schools. It stated that schools should be "a primary location for service delivery" (p. 20), citing data out of New Brunswick that found that attrition for MHSUD programming dropped from about 50% to almost 0% when supports were located in schools for youth. This is the only example in the documents analysis, where schools were seen as the key agents of coordinated and integrated policy approach.

In the *Pathway to Hope* document, emerging out of BC/SSCCY recommendations, shared cross-sector priority actions are orchestrated by BC/MMHA, but with all policy actors at the table, "across ministries, with Indigenous partners and service delivery partners [to] build a culturally safe and effective system of care" (BC/MMHA, 2018, p. 9). Outcomes and priority actions include key activities for mental health in schools including integrated child and youth treatment teams, "linking together existing services in new ways and investing in new services…across ministries, with Indigenous partners and service delivery partners to build a culturally safe and effective system of care that benefits young people (BC/MMHA, 2018, p. 18). Additionally, from the perspective of providing multi-tiered systems of support, there is evidence of collaboration across tiers. Integrated youth teams in schools support multi-tiered interventions in schools and cross-supported by health, education, BC/MCFD which serve as:

> community-based interdisciplinary teams that deliver wraparound mental health and substance use services and supports…[via] outbound services that meet children youth, and families where they choose, outreach services working closely with schools, early years services and primary care, and will connect children and youth to specialized and higher intensity services when needed. Core members include child and youth mental

> health clinicians, youth substance use clinicians, education counsellors, youth and family peer support workers, Indigenous positions, and ICY program leaders. (BC/MMHA, 2021, p. 24)

Coordination and collaboration with Indigenous communities and the TRC Calls to Action. In the provincial BC context, direction related to Indigenous representation and influence comes from multiple sectors including social services (BC/MCFD), health (BC/MH), Indigenous issues (BC/AFN), and mental health (BC/MMHA). Part of provincial mental health service provision, Indigenous Child and Youth Mental Health Services endeavours to "[work] in a way that is respectful of Indigenous knowledge is key to helping children, youth and their families over some their mental health concerns" (BC/MMHA, 2023, p. 5). BC/MCFD's CYMH Teams also have mental health teams tasked to work specifically with Indigenous youth with understandings of trauma-informed and culturally relevant care (2015). The 2015 *Aboriginal Policy and Practice Framework for British Columbia* (BC/MCFD) is a guideline document intended to support public service workers in understanding the positionality of Indigenous youth and ways to ensure culturally relevant and reconciliation-based supports for youth. BC/AFN (2020) presents a document that frames Indigenous wellness paradigms as unique from Western paradigms in which gross domestic product is often a primary metric for community health. These services and supports for Indigenous youth claim to acknowledge "specific First Nations groups with traditional teachings in each area" and work with local First Nations to develop responsive approaches (BC/MMHA, 2023) to MHSUD which consider success outside of economic models. That is across sectors and across examined policy documents, there is evidence of co-planning with Indigenous communities and increased funding to Indigenous initiatives (BC/MMHA, 2021) beyond service provision and utilization of Jordan's Principle (as

was seen in the Manitoban policy subsystem). The estabilishment of different models of service provision, rather than simply adding funding to historical models of service provision, demonstrates expansion of Indigenous paradigms of care and the development of new pathways to support policy integration.

Key takeaways: BC data set. In the BC data set, there is strong evidence of cross-sector frameworks with aligned policy actions. Framing of MHSUD as an issue of socio-ecological health follows the federal arc where policy has moved in recent years from answering to safety concerns, to answering to health care provision, to being framed around cross-sectoral understandings of wellness. However, though there are shared values across stakeholder groups in policy actions, we still see in the BC data set the need to tackle stigma issues head-on, both in a need to justify policy actions in terms of financial means, and in discussion of the *Pathway* document about the ways in which stigma impedes care. This suggests, as in the two above data sets, that there is still a mix of discourses of intent and secondary beliefs driving policy action in the BC data set as well.

Material policy actions in service to symbolic commitments are seen most notably following the 2018 *Pathway* document which directs independent ministries in support of a common purpose. Key exemplars of policy integration are noted in two areas of the BC policy framework. The first is in the BC/SSCCY, a cross-sector, non-partisan body which reviews recommendations made by the Representative for Children and Youth, and then completes independent reports to the legislature with the interests of children and youth in mind. There is a strong link between policy recommendation and material actions as shown in the analysis in response to this standing committee by virtue of a shared vision, access to funding sources, representation from pan-provincial policy actors, and a mandate to respond to grass roots reports

with fidelity of implementation. A second key example of a coordination mechanism that is working is the way in which the BC/MMHA has collaborated alongside other ministries to determine a shared mandate with individual implementation directives. Similar to the federal exemplar of the *National Drug Strategy*, this common plan overseen by one ministry (HC) involves strategic plans with clear objectives in parallel ministries (including the Department of Justice, Border Services among others). However, even with the strategy laid out in the *Pathway* (2018) document, there is some confusion with regards to how the mandate of various policy actors may overlap. For example, it is not clear how BC/MCFD youth mental health services fit into a the tiered school-provided MHSUD supports from education and health. Primary prevention strategies, the newly initiated ICYTs at the targeted level and Step-up/Step-down beds at the intensive level of supports provided by MH (BC/MMHA, 2018) are not discussed in reference to BC/MCFD supports at all.

Regional Stakeholders: Manitoba

Documents from the following four regional stakeholders were reviewed as regional stakeholders for Manitoba:

- Winnipeg Regional Health Authority (WRHA)
- Shared Health Manitoba (SH)
- Winnipeg School Division (WSD)
- Southern Chiefs Organization (SCO)

Discourses of intent: What are the stakeholders' interests and beliefs? Using the same process for coding for signifiers and identifying discourses of intent used above, at the regional level, four discourses of intent were identified:

1. **Service provision for MHSUD** and wellbeing
2. **Assessment of existing resources** for MHSUD
3. Treatment of **MHSUD as a cross-sector issue** with intent to minimize harms; and
4. Administration of **safe schools**

Table 5.13 outlines the key discourses of intent, and examples of the discourses of MHSUD which were used to support each discourse of intent.

Table 5.13
Discourses of Intent and Discourses of MHSUD in Manitoba Regional Documents

Dominant Discourse-of-Intent	Time-frame	Stake-holders	Examples of Discourses of Interests Supporting the Discourse-of-Intent	Discourses of MHSUD Beliefs Supporting Discourses of Intent
Service Provision for MHSUD *RM1, RM5, RM8, RM9, RM13*	2022-2023	WRHA SH WSD SCO	• "provide range of mental health services" to promote mental wellbeing" (WRHA, 2023) via "a responsive and inclusive system" (SH, 2023) • "provide supports and resources to students, to their families and to staff" (WSD, 2023) with "access to supports for success" (SCO, 2022). • "work… with government to help ensure that all Indigenous children are receiving adequate services, programs, and opportunities that will enhance their wellbeing" (SCO, 2023)	**Socio-ecological Health Issue** • "the capacity…to enjoy life and deal with the challenges we face" (WRHA, 2023). • "Wellness from an Indigenous perspective is a whole and healthy person expressed through a sense of balance of spirit, emotion, mind and body. Central to our wellbeing is a belief in one's connection to our language, land, creation (nature), history (ancestry) that is supported by a caring family and environment" (Southern Chiefs Organization, 2023) **Public Health Issue** • "psychiatric or emotional disorders"; "mental health"; "addiction" (SH, 2023) • "mental health needs" (WSD, 2023) rooted in a "continuum of preventative, developmental and intervention services:
Assessment of existing resources for MHSUD *RM3, RM4, RM7*	2014-2019	WRHA SH	• Public assessment of existing health care in the WRHA with goal of "population health" and "health equity" (WRHA, 2019) • Share health care data for effective decision making" with regards to service provision (WRHA, 2014)	**Socio-ecological Health Issue** • MHSUD related to social determinants of health" (WRHA, 2019, p. 6), influenced by "social, psychological and biological factors" (WRHA, p. 19). **Safety Issue** • Substance use "associated with injuries and deaths, vandalism, alcohol poisoning and violence…[and] a number of acute and chronic disease conditions" (WRHA, 2019, . p. 17) • Complicating health management provincially (Shared Health, 2019, p. 28)
Minimize harms from by treatment as a cross-sector issue *RM2, RM6*	2019-2023	WRHA SH	• Commitment to finding as many ways as possible to work together (WRHA, 2023) • Manitoba clinical providers and health system leaders… collaborate on a provincial plan" (Shared Health, 2019).	**Public Health Issue** • "mental illness", "mental health disorder", "substance abuse problem" are a "significant contributor to the disease burden" (WRHA, 2014, p. 38) • Mental health, addictions cited with other health care concerns: prevention, chronic conditions, primary care, home care as part of a health care mandate
Safe Schools *RM10-12*	2019	WSD	• Provide a safe and caring school environment" (WSD, 2019); "safe and orderly schools" (WSD, 2019, p. 1)	**Safety Issue** • Substances that may "threaten public safety"; listed alongside weapons (WSD, 2020, p. 2)

In the Manitoban regional data set, the discourse of intent of service provision for MHSUD was found to be centered around an intent to "provide range of mental health services"

(WRHA, 2023) via "responsive and inclusive system[s]" (SH, 2023). This was supported by iterations of MHSUD as a biomedical health and socio-ecological health issue. Biomedical health discourses of MHSUD included discussions of mental health needs rooted in a continuum of preventative, developmental, and intervention services (WSD, 2023). MHSUD as a socio-ecological issue was supported by discourses of MHSUD related to social determinants of health" (WRHA, 2019, p. 6), influenced by "social, psychological and biological factors" (WRHA, p. 19).

The discourse of intent of assessment of existing resources for MHSUD was utilized in the Manitoban context, supported by understandings of MHSUD as a safety issue and a socio-ecological health issue. For example, as "associated with injuries and deaths, vandalism, alcohol poisoning and violence…[and] a number of acute and chronic disease conditions" (WRHA, 2019, p. 17). In these cases, assessment of current resources is intended to share health care data to support effective decision making with regards to service provision (WRHA, 2014) and thus, arguments of public safety seem to be utilized as an attempt to mobilize additional support. Concerns of safety are also primary in supporting a discourse of intent of safe schools. The discourse of intent of cross-sector service delivery frameworks are supported by discourses of MHSUD as a public health issue in Manitoba. An example of this is a reference to MHSUD as a "significant contributor to the disease burden" (WRHA, 2014, p. 38).

Themes related to discourses of intent. With few exceptions, the discourses of intent at the regional level are attached to either establishment of service delivery frameworks or direct service provision. For example, even when there is a discourse of intent of considering socio-ecological positioning of MHSUD, there is a call for "Manitoba clinical providers and health system leaders… collaborate on a provincial plan" (Shared Health, 2019). There seems to be a

consideration of recruiting cross-sector collaboration in service of the development of a biomedical based service delivery framework with steering from health authorities. Exceptions to this regional emphasis on a service provision mandate driven by health care, are documents advocating for safe schools and documents working to assess mental health approaches. This is arguably due to the positionality of regional actors in the federalist system, where provincial governments legislate health authorities, school divisions, and social services agencies to enact legislation in the form of service delivery. This is also indicative of historical positioning of regional mandates for MHSUD care in Manitoba centered in the health system.

However, as noted in the Virgo Report (2018) explored above, there has been significant criticisms of the ways in which existing MHSUD supports for youth have been able to meet the needs of youth. For example, in an absence of enough treatment options to support youth, the Virgo Report (2018) noted that clients are "lost in space between different referrals and transitions to different levels of service" (p. 160). It is perhaps in this context that we see some emerging policy actions from CFS to support mental health care for youth in care. For example, the SCO has committed to "provide supports and resources to students, to their families and to staff" (WSD, 2023, p. 1) and to "work… with government to help ensure that all Indigenous children are receiving adequate services, programs, and opportunities that will enhance their wellbeing" (SCO, 2023, p. 1). This work is done via a service provision partnership with MacDonald Youth services, which demonstrates a departure from provincial CFS policy where MHSUD is not named. This highlights an emergence of regional actors to taking on discourses of intent not mapped out provincially to respond to actual need.

In the case of the discourses used in school documents from the WSD, however, with the exception of documents related to the Code of Conduct and disciplinary responses, there is

notably very few directive policies which name MHSUD as a policy problem. In terms of support services assigned to schools, "mental health needs" (WSD, 2023) are mentioned as part of a "continuum of preventative, developmental and intervention services" (p. 1) alongside other needs as part of appropriate educational programming. This seems to be in keeping with the provincial Manitoban landscape which uses terms like "wellness" and "support" to plan for MHSUD without clear directives for MHSUD as a distinct policy problem.

There appears to be a lack of shared values at the regional, service-provision level, where actors verbalize commitments to the development socio-ecological service provision frameworks, but without common values supporting such a framework across sectors. For example, though the WRHA acknowledges MHSUD as related to social determinants of health, influenced by "social, psychological and biological factors" (WRHA, p. 19), it still couches responses in medical language of "mental illness," "mental health disorder," "substance abuse problem," and MHSUD's "significant contributor to the disease burden" (WRHA, 2014, p. 38). SH, which has been tasked with managing MHSUD services provincially following health care restructuring and the dissolving of AFM (Government of Manitoba, 2021), frames MHSUD as "complicating health management provincially" (Shared Health, 2019, p. 28). By comparison, the SCO frames understandings of MHSUD care and wellness as:

> a whole and healthy person expressed through a sense of balance of spirit, emotion, mind and body. Central to our wellbeing is a belief in one's connection to our language, land, creation (nature), history (ancestry) that is supported by a caring family and environment (SCO, 2023, p. 1).

In sum, from a values perspective, there is symbolic policy in the Manitoban regional policy subsystems advocating for

> the responsibility of all levels of government and the organizations which they further delegate responsibilities, commission work and distribute funds which affects all sectors of society… such as healthy community planning, intersectoral action on health, healthy public policy…health as a human right" (WRHA, 2019, p. 14).

However, this strong emphasis on socio-ecological health equity seems to have its foundations in different understandings of the imperative of MHSUD care, essentially rooted in safety, economics, service provision, and/or colonialism. This fragmentation includes regional policy actors referencing the need for cross-sector provision of services, without evidence of a shared vision.

Discourses of action. Policy actions at the regional level in Manitoba are seen in the forms of websites outlining services, service provision frameworks, service provision partnerships, strategic plans and service plans, community health assessments, and organizational policies for implementation. Table 5.14 outlines the policy actions associated with discourses of intent, organized by policy actor. As with past stakeholder groups, I investigated: (a) whether policy actions are material or symbolic; and (b) how these policy actions impact schools.

Table 5.14 Policy Actions Associated with Discourses of Intent in Regional-Manitoban Documents

Discourses of Intent	Policy Actor Supporting this Discourse-of-Intent	Policy Actions Associated with Discourses of Intent	
		Material Policy Actions	Symbolic Policy Actions
Service Provision for MHSUD *RM1, RM5, RM8, RM9, RM13*	**WRHA**	• Service provision website to direct access to MHSUD services in the WRHA, including primary prevention and specialized services for MHSUD (2023)	• Wellbeing guide: Ways to support wellbeing (2023)
	SH	• Continuum of services for MHSUD: community based, brief interventions, hospital, long term treatment (2023)	• None identified
	WSD	• Partnership between WSD and SCO to provide Jordan's Principle Coordinator role to access services for youth including MHSUD services (2023b)	• None identified
	SCO	• Social service provision for youth including support accessing MHSUD services and broader support for socio-ecological health	• None identified

		including funding, referrals, support workers (2023)	
Assessment of existing resources for MHSUD *RM3, RM4, RM7*	**WRHA**	• None identified	• Community health assessments present statistics on health outcomes and health behaviours in Manitoba (WRHA, 2014, 2019) • Promising practices related to ensuring health equity and facilitating partnerships to amplify health equity (WRHA, 2019)
	Shared Health	• None identified	• Audit of to-date implementation of the Shared Health Healing our Health System plan (2019) including an assessment of current markers and status, and recommendations for next steps of the plan
Minimize harms from MHSUD by treatment as a cross-sector issue. *RM2, RM6*	**WRHA**	• None identified	• Strategic Plan for the WRHA with regards to service provision in community (2022)
	Shared Health	• None identified	• Strategic Plan for Shared Health, including MHSUD service provision via district sites to create an "integrated and effective provincial health system" (Shared Health, 2019, p. 5); MHSUD services are consolidated provincially and at particular sites
Safe Schools *RM10-12*	**Winnipeg School Division**	• Policy outlining when search and seizure can be completed by schools for suspected drug/alcohol infraction (2020) • Framework for clinical support services in schools including: school counsellors, social workers, psychologists with service mandates including MHSUD (2023a)	• Policy outlining school division commitment to safe and caring school environments, including the ministerial directive of development of Codes of Conduct (2019) • Policy outlining school division's commitment to restorative disciplinary practices (2022)

Symbolic and material policy actions. At the examined regional level in the Manitoban context, symbolic policy actions are generally made up of commitments to action in the form of strategic plans and service plans. Material policy actions take the form of service provision or referral for service provision for MHSUD. That is, symbolic policy actions in general chart the pathway for how services are meant to be provided, and then the material policy actions are wielded to enact those plans. In the sense that most service provision is enacted through health authorities, under direction of the ministries of health and mental health, it is instructive to assess the themes present in strategic directions from the RHA's in both jurisdictions. The purpose is to consider how they are aligned with provincial discourses and to understand the value positions they are upholding. In the case of the Manitoban health authorities (WRHA and SH), strategic plans fall in the wake of considerable work to re-allocate and re-structure health care services. For example, by dissolving AFM and bringing MHSUD services under the umbrella of Shared Health (SH, 2023) progress to support MHSUD has been conflated with re-organization of supports. This is achieved through the creation of key district sites as points of entry for mental

health teams via a “consolidation of metal health services" (SH, 2019). This consolidation, intended to “coordinate where services are offered” (SH, 2019), was enacted following the Virgo Report (2018) which pointed out that MHSUD care in Manitoba was confusing and fractured, partially due to too many access points. However, the result is that the primary theme in strategic plans for the examined RHA’s in Manitoba is one of organizational politics focused on consolidation of services, to the point where the WRHA’s 2023 strategic plan does not mention mental health or substance use in strategies, actions or goals, despite being a primary access point to service providers on their website and through primary practitioners (WRHA, 2021). That is, it seems that MHSUD reform has been hitched to the wagon of health care governance reform so that strategic plans are focused on managerial issues. For example, a 2020 document from Shared Health finds that, “the shift of mental health services from five sites to three has improved management of these services significantly” (p. 42), suggesting that an overarching policy goal is managerial in nature.

Action-based discourses in relation to schools[17]**.** As is the case with Manitoban provincial education policy, policy actions related to MHSUD in the WSD do not include directive MHSUD policies, but rather MHSUD responses and supports are touched or peripherally embedded in other policy actions. For example, policy actions for MHSUD are embedded in policy actions for safe schools and codes of conduct (WSD, 2019), support services for students with additional needs (WSD, 2023a), and partnerships with Jordan’s Principle to support provision of medical services (WSD, 2023b). This means that although school staff are tasked with meeting the needs of students each and every day, including supporting safe schools

[17]Though deemed beyond the scope of this policy analysis, both the VSB and the WSD implement provincial Health curriculum which includes preventative education for youth on MH and SUD. Along with this, there are policies in both jurisdictions which allow families to request exemptions for their children (WSD, 2004). Curriculum documents were not part of the inclusion criteria for this project.

policies and working with families to support students with additional needs, in the absence of provincial policy directives for MHSUD in schools, this is done through veiled policy directives.

Discourses of coordination. I coded for the presence of coalitions, evidence of vertical or horizontal coordination, the level of coordination and opportunities for and barriers to coordination in the regional subsystems. Themes uncovered are presented in Table 5.15.

Table 5.15 Coalitions, Types of Coordination and Barriers to Coordination in Regional (MB) Documents

Discourses of Intent *Stakeholders and Timelines Involved in the Discourse*	**Policy Actor Supporting this Discourse - of-Intent**	**Coalitions – existing partnerships with policy actors** **(By Policy actors)**	**Opportunities or Barriers to coordination** **(By policy actor)**		
			Evidence of Vertical or Horizontal Coordination	**Low level service coordination or policy integration**	**Key Opportunities and Barriers:** • **Shared Values/Lack of Shared Values (SV/LSV)** • **All Policy Actors Present (APAP)/ Not Present (PANP)** • **Fidelity Implementation (FOI)/ Lack of Fidelity (LFI)** • **Funding Decisions at Same Level (FDSL)/ Different Levels (FDDL)**
Service Provision for MHSUD *RM1, RM5, RM8, RM9, RM13*	WRHA	**Provincial** • Addictions Foundation of Manitoba **Regional** • Service Providers: Clinical Health Psychology Service, hospitals, Manitoba Adolescent Treatment Center, Crisis Stabilization Unit, etc. • WRHA: Indigenous Health Unit	Vertical Coordination: Health Authority Mandate of Service Delivery Framework	Service Coordination	FOI • Multiple access points to get on triage lists—evidence of the intent to coordinate via centralized intake for all services (2023) PANP • Provincial directives on cross sector not seen at regional level; interventions are solely from perspective of health—education, social services not cited. WRHA Indigenous supports cite but not spelled out in terms of how these supports might differ (2023)
	Shared Health	**Federal** • None identified **Provincial** • Addictions Foundation of Manitoba **Regional** • Service Providers including: MATC, Crisis Stabilization Unit, hospitals, etc.	Vertical Coordination: access points for service provision	Service coordination	FOI • Multiple access points to get on triage lists—evidence of the intent to coordinate via centralized intake for all services with WRHA and child and adolescent mental health program (2023) PANP • Provincial directives on cross sector not seen at regional level; interventions are single-sector—education, social services not cited.
	Winnipeg School Division	**Federal** • None identified **Provincial** • Ministry of Education • Ministry of Health **Regional** • RHAs • Service providers for MH	Horizontal	Policy Integration	PANP • No references to MHSUD supports beyond school system (2023a) • AFM partners with some school divisions; not WSD which shows that fractured response results in inequity of services LSV • MHSUD shared as a priority in school; though mental health is named alongside other needs (cognitive, speech-language) it does not have any clear directives for a tiered MHSUD response (2023a)
	Southern Chiefs Organization Child and Family Services Authority	**Federal** • An Act Respecting First Nations, Inuit and Metis Children, Youth and Families **Provincial** • No **Regional** • MacDonald Youth Services • Member CFS Agencies	Horizontal	Policy Integration	SV, PANP • Though provincial symbolic policy actions support cross-sectoral responses, there is a lack of provincial direction in linking social supports with MHSUD supports. Given this lack of orchestration, regional partnerships emerge. In this case, SCO and MYS commit to the following: "creation of a governance framework that is guided by the principles of reconciliation…[d]esigning and building a community care model consistent with the evolution of the child welfare system as contemplated by southern First Nations" (2023)
Assessment of existing resources for MHSUD *RM3, RM4, RM7*	WRHA	**Provincial** • Manitoba Health and hired consultancies • Healthy Child Manitoba • AFM **Regional** • Center for Healthcare Innovation			PANP, LOI • Only representatives from education in the form of Health Child Manitoba (now defunct); no long term policy or legislation integration • Declarations of cross-sector opportunities are not met with roadmaps or input from non-health sectors: "community supports and wraparound that meet the unique needs of individuals and families are needed…

		• Children's Hospital Foundation of Manitoba • Health Authorities • Service Delivery Organizations			these may include partnerships with schools, enhancement of social networks and a focus on resiliency and family wellbeing" (2019, p. 8). No education or social stakeholders referenced
	Shared Health	**Federal** • None identified **Provincial** • Doctors Manitoba • Ministry of Health **Regional** • Health Authorities • Hospitals, service providers	Vertical – province to RHAs; Horizontal – service providers with each other	Service Coordination	PANP, LSV • "mental health resources have been augmented beyond hospital care into community resources" (2019b, p. 14) • Recommendation that "mental health and addiction funding be diverted from general practitioners other than those with recognized training" (2019b, p. 17) FOI • "mental health and addictions be supported in a restructure of all related services and that regional hubs outside WRHA be" identified hospitals in each RHA (2019b, p. 18)
Minimize harms from MHSUD by treatment as a cross-sector issue. *RM2, RM6*	WRHA	**Federal** • None identified **Provincial** • Ministry of Health **Regional** • Service providers: hospitals, etc.	Vertical – service delivery framework	Service coordination	LSV • 2023 strategic plan for WRHA does not reference MHSUD. Possibly since it has been passed to Shared Health. Shared Health speaks to an organizational framework within health – no broader context (2022)
	Shared Health	**Federal** • None identified **Provincial** • Ministry of Health **Regional** • WRHA • Service providers	Vertical – service delivery framework	Service coordination	LSV, PANP • Actual policy implementation does not align with policy goal to support multi-faceted response to MHSUD (including other policy actors) – move to identified hubs and removal of MHSUD supports from RHAs reacts to intensive needs and hospitalization but not a continuum of supports (2019a)
Safe Schools *RM10-12*	**Winnipeg School Division**	**Federal** • Canadian Charter of Rights and Freedoms **Provincial** • Ministry of Education • Youth Criminal Justice Act • Education Administration Act	Vertical	n/a – no coordination, just administration of provincial directives	LSV • Provincial directives to regional bodies regarding what must be in place for code of conduct, search and seizures (2020) • Though reference to consideration of appropriate disciplinary responses, including restorative responses, disciplinary document does not reference social and health-based interventions cited in 2023a.

Despite provincial directives including commitments to invest in cross-sector MHSUD responses (MB/MMHCW, 2022), there is limited evidence of cross-sector policy actions at the regional level in Manitoba. Data shows that in the case of health service provision, vertical coordination is most prominent, taking the form of RHAs which delegate and manage service provision in geographical areas. However, significant emphasis in recent years on consolidation of health care services (Government of Manitoba, 2021) has resulted in coordinated actions for system access; for example, the establishment of multiple access points to get on triage lists for consolidated MHSUD as evidence of the intent to coordinate via centralized intake for all services (WRHA, 2023). Outside of the health sector, horizontal coordination mechanisms are more common. Though provincial symbolic policy actions support cross-sectoral responses, there is a lack of provincial direction in linking social supports with MHSUD supports. Given this lack of orchestration, regional partnerships have emerged. In this case, SCO and MYS commit to the following: "creation of a governance framework that is guided by the principles of reconciliation…[d]esigning and building a community care model consistent with the evolution of the child welfare system as contemplated by southern First Nations" (2023, p. 2). That is, in absence of coordination from regional actors, policy integration and service coordination relationships seem to be forged by service providers. Other examples of lower-level service coordination include schools and school divisions forming partnerships with AFM (2023) and therapy providers for MHSUD supports (Norwest Hub, 2023). However in absence of provincial direction, these types of low-level service agreements seem to be implemented without consistency. For example, WSD does not have any policy evidence of partnerships with MB/AFM or MHSUD therapy providers. Insofar as some school divisions themselves have built

these partnerships, the reliance on ground-level organizations to form coalitions seems to result in inequalities in cross-sector MHSUD implementation.

Coordination and collaboration with Indigenous communities and the TRC Calls to Action. In the regional subsystem in Manitoba, there are few dedicated actors building vertical Indigenous service delivery pathways for MHSUD at the ministerial systems level. At the regional level, we do see collaboration pathways with Jordan's Principle being built to fund service provision (WSD, 2022). This suggests that there is a demonstrated need for service provision for Indigenous youth that is significant enough that regional systems (for example, WSD and SCO) are taking initiatives to build frameworks that support effective service provision in absence of other service provision pathways. Though the RHAs take the lead on MHSUD service provision in regional jurisdictions in Manitoba, in the examined policy actors, there was not evidence of clear policy mandates to support coordination with Indigenous groups. For example, the WRHA does cite Indigenous supports as being important for responsive systems, but it is not clear in the policy documentation how these supports might differ from existing sectorial responses (WRHA, 2023).

Key takeaways. Among the identified regional jurisdiction in Manitoba, it is clear that in keeping with a federalist model of governance, there is an emphasis on service provision at the regional levels of heath, CFS, and education. However, despite acknowledgement of MHSUD as a socio-ecological issue embedded in social, health, cultural, and educational positioning, there is little evidence that these separate ministries are tackling service provision for MHSUD in cross-sectoral manner. Though there is some evidence of coordination, specifically, coordination within health authorities which tends to be in the form of consolidation via intra-sectoral actions focused around health care restructuring (for example, a managerial approach). In sectors of

education and CFS, there is evidence of the emergence of regional and sub-regional partnerships in spite of lack of provincial or regional coordination, with resulting inconsistent application. For example, SCO's partnership with MYS to provide an internal continuum of MHSUD supports for youth in care is not linked to a provincial mandate which would provide this type of support for youth in care of other CFS agencies. School divisions partnerships with AFM (now called Shared Health – Substance Use Services), Norwest Hub, and other MHSUD therapy providers, and funding collaborations with Jordan's Principle have also been forged at the regional level and funded out of existing budgets. The reliance on (inconsistent) service-level partnerships without provincial funding or coordination is particularly evident with education funding for MHSUD care in schools, which lacks consistency between school divisions. What we see in the regional Manitoban jurisdiction is fragmented and inconsistent regional and sub-regional collaboration stemming from a lack of shared vision, provincial funding supports, and representation of policy actors outside of sub-regional service arrangements.

Regional Stakeholders: British Columbia

Documents from four stakeholders were reviewed representing the identified regional stakeholders in BC, including: Vancouver Health Authority (VHA), First Nations Health Authority (FNHA), Provincial Health Authority (PHA) and the Vancouver School Board (VSB).

Discourses of intent: What are the stakeholders' values and beliefs? Using the same process for coding for signifiers and identifying discourses of intent used above, at the regional level, the following discourses of intent were identified:

1) **Service provision for MHSUD** and wellbeing;
2) Treatment of **MHSUD as a cross-sector issue** with intent to minimize harms; and

3) Administration of **safe schools.**

Table 5.16 outlines the key discourses of intent, and examples of the discourses of MHSUD which were used to support each discourse of intent.

Table 5.16 Discourses of Intent and Discourses of MHSUD in BC Regional Documents

Dominant Discourse-of-Intent	Time-frame	Stake-holders	Examples of Stakeholders Interests Supporting the Discourse of Intent	Examples of Stakeholder Beliefs of MHSUD Supporting Discourses of Intent
Service Provision for MHSUD and Wellbeing *RBC1, RBC3, RBC5, RBC6,*	2023	VCHA	• "interdisciplinary behavioural and mental health assessment and treatment services" (2023, p. 1)	**Public Health Issue** • "substance use and substance related problems"; mental health "challenges" (2023)
	2023	FNHA	• Provide "culturally safe and trauma-informed cultural, emotional and mental health services" (2023, p. 1)	**Socio-ecological Health Issue** • Support for MHSUD in form of "healing journeys", MHSUD as linked to trauma (2023) • "health issue, not a moral issue" (FNHA, year, p.8)
	2023	PHA	• "provide… specialized treatment for people with… severe" MHSUD (2023, p. 1)	**Public Health Issue** • MHSUD requiring specialized treatment in medical facility (2023)
	2023	VSB	• Provision of mental health services by school staff, referral to outside agencies (2023)	**Socio-ecological Health Issue** • "health and wellness" rooted in "social emotional and mental health literacy" (2023a)
Minimize harms from MHSUD by treatment as a cross-sector issue *RBC2, RBC4, RBC7*	2021	VCHA	• improve access and quality of MJHSUD services including non-health care partners (2021)	**Social Issue** • "rising burden" of MHSUD (2021, p. 8) targeting "those who are vulnerable" (2021, p. 12)
	2021	FNHA	• "trauma-informed care, enhancing access to mental health with culturally competency and implementing harm reduction strategies" (2021, p. 4)	**Socio-ecological Health Issue** • MHSUD a result of the need to "[heal] from the impacts of trauma, colonialism and Indigenous-specific racism" (2021, p. 38); a "continuum" (2021, p. 36)
	2023	VSB	• "prevent substance use, delay substance use, and reduce substance use related problems" (2023b)	**Public Health Issue** • responsive to tiered supports including, "prevention and early intervention" (2023b)
Safe Schools *RBC8*	2023	VSB	• safe and caring schools (2023)	**Safety Issue** • MHSUD limited to consequences for "banned substances" (2023c)

In the Vancouver regional context, the discourse of intent of service provision for MHSUD was found to be centered around an intent to "provide range of mental health services" (WRHA, 2023) via "responsive and inclusive system[s]" (SH, 2023). This discourse of intent is supported by iterations of MHSUD as an issue of public health and socio-ecological health issue. Public health discourses of MHSUD incorporated discussions of mental health needs (WSD, 2023) rooted in a "continuum of preventative, developmental and intervention services", including provision of MHSUD treatments in medical facilities (PHA, 2023). MHSUD as a socio-ecological issue was evident through the language where MHSUD was related to "social

determinants of health" (WRHA, 2019, p. 6), influenced by "social, psychological and biological factors" (WRHA, p. 19), and the need to "[heal] from the impacts of trauma, colonialism and Indigenous-specific racism" (FNHA, 2021, p. 38).

The discourse of intent of cross-sector service delivery frameworks is supported by iterations of MHSUD as a socio-ecological health issue in VCHA, FNHA and VSB documents. VCHA and FNHA both emphasize cross-sector service delivery and/or understandings of MHSUD as a socio-ecological phenomenon, relating MHSUD to socio-cultural determinants of health, influenced and acknowledging the need to "[heal] from the impacts of trauma, colonialism and Indigenous-specific racism" (FNHA, 2021, p. 38). However, single sector responses rooted in biomedical health were still seen in the PHA where MHSUD was discussed as requiring specialized treatment in medical facility (2023). Single-sector responses rooted in discourses of safety were seen in the VSB—in discussions of MHSUD limited to consequences for "banned substances" (2023c).

However, elsewhere in school-based documents, the BC regional data set also showed treatment of MHSUD as a socio-ecological health phenomenon where "health and wellness" is acknowledged as being rooted in "social emotional and mental health literacy" (VSB, 2023a, p. #). The VSB demonstrates commitments to cross sector service delivery frameworks for MHSUD via the *Substance Use Prevention Initiative* and other service delivery frameworks for youth support services where MHSUD is overtly named (2023a, b).

Discourses of action. Policy actions at the regional level in BC were seen in websites outlining services, service provision frameworks, service provision partnerships, strategic plans and service plans, community health assessments and organizational policies for implementation. Table 5.17 outlines the policy actions associated with discourses of intent, organized by policy

actor. As with past stakeholder groups, I investigated: (a) whether policy actions are material or symbolic; and (b) how these policy actions would impact schools.

Table 5.17 Policy Actions Associated with Discourses of Intent in Regional (BC) Documents

Discourses of Intent	Policy Actor Supporting this Discourse-of-Intent	Policy Actions Associated with Discourses of Intent	
		Material Policy Actions	**Symbollic Policy Actions**
Service Provision for MHSUD *RBC1, RBC3, RBC5, RBC6,*	**VCHA**	• Administration of comprehensive assessment and treatment plan for youth (2023) • Psychiatric, therapeutic and health care supports for MHSUD (2023)	• None identified
	FNHA	• Culturally safe, trauma informed MHSUD service provision including: virtual doctor of the day, additional access points for culturally relevant care (2023)	• None identified
	PHA	• Provision of specialized treatment for intensive cases of MHSUD involving hospitalization and court orders (2023)	• None identified
	VSB	Provision of MHSUD student support via: • In school staff: classroom teachers, counsellors, including the Expect Respect and a Safe Education (ERASE) Strategy • Division staff: area counsellors, psychologist • Referrals to outside services/ agencies (including: Kelty Mental Health, Foundry BC) (2023a)	• None identified
Minimize harms from MHSUD by treatment as a cross-sector issue. *RBC2, RBC4, RBC7*	**VCHA**	• None identified	• commitment to ensure "everyone is attached to a full-service primary health provider…part of a primary care network…who work in team-based practices [with] other professionals" who manage MHSUD care (2021, p. 12) • commitment to "enhance mental health and substance use services" (2021, p. 18) via ongoing support for interdisciplinary teams, improvement of transitions from hospital to community-based supports.
	FNHA	• None identified	• Commitment to work with government partners to invest in First Nations-operated treatment centers and a "comprehensive continuum of mental health and wellness approaches" (2021, p. 38) • Enhancement of supports for youth (2021)
	VSB	• *Supporting and Connecting Youth: Substance Use Health Promotion Initiative:* tiered "coordinated prevention and early intervention strategies that emphasize relationships, connectedness, positive youth development, and social emotional learning" to embed proactive strategies to combat youth MHSUD. Including: youth teaching and prevention, learning and engagement opportunities, curriculum and teacher training (2023b)	• None identified
Safe Schools *RBC8*	**VSB**	• Criteria for disciplinary action involving a student in possession of/ under the influence of drugs/alcohol, including: appropriate disciplinary responses (including restorative and "alternate" disciplinary responses, search and seizure protocols, protocols for involvement of outside agencies (CFD, Police) (2023c)	• None identified

Symbolic policy actions in the examined RHAs in British Columbia are aligned in a commitment to "enhance mental health and substance use services" (RHA, 2021, p. 18) via ongoing support for interdisciplinary teams and improvement of transitions between different supports. This seems to be in direct response to a provincial report from the BC/MMHA (2018) which found disjointed services and confusing triage processes in the British Columbia/ Vancouver policy subsystem. With this backdrop, there is policy evidence that RHAs in the BC jurisdiction have responded not through consolidation of services and access points, as was the case in the Manitoban regional data set, but through proliferation of services and access points. The creation of interdisciplinary teams and a commitment to ensure "everyone is attached to a full-service primary health provider…part of a primary care network…who work in team-based practices [with] other professionals" (2021, p. 12) who manage MHSUD care has resulted in a growth of access points. Interdisciplinary teams include action and input from First Nations-operated treatment centers with a "comprehensive continuum of mental health and wellness approaches" (FNHA, 2021, p. 38) and "framework[s] to support region-specific trauma informed mental health and wellness supports" (FNHA 2021, p. 2). BC's PHA maintains control of intensive hospitalization services in a traditional bio-medical consolidated model of health. That is, in the BC data set there is some evidence of consolidation of policy action at the most intensive tiers of service provision, but a proliferation of access points and service provision models at other tiers indicates a lack of consolidation at universal and targeted levels of support.

Policy actions in schools. In Vancouver, policy actions include safe schools policies (VSB, 2023c) and support services policies (2023a) along with tiered MHSUD responses. These include, for example, "interdisciplinary… mental health assessment and treatment services" for school-aged children (VCHA, 2023), mental health referrals to outside agencies including

Foundry BC and Kelty Mental Health (VSB, 2023), support services for additional needs within the school environment (VSB, 2023), and the *Substance Use Health Promotion* (2023) initiative which includes preventative programming, teacher training, support services. In addition, though not identified in the regional data set due to its recent launch, the provincially-funded Integrated Child and Youth Teams provide MHSUD services in schools. These additional material policy actions to support youth in Vancouver schools seem to be related to some key differences in the BC policy subsystem, including; (a) the presence of a provincial Mental Health Strategy for Schools (2020); (b) provincial precedence setting in terms of cross-sector collaboration; and (c) the longer implementation time of the Ministry of Mental Health and Addiction.

However, the plethora of services in Vancouver schools is not without issue in the context of calls for improved access (MMHA, 2018). Whereas the Winnipeg jurisdiction of consolidation has worked to bring existing regional service providers in line with singular access points via a managerial model, the Vancouver context, as seen through the eyes of school-based access, seems at first glance to be a confusing one. While the VRHA states that they provide integrated mental health assessments in Vancouver Schools, the VSB website directs students and families to outside providers (including, Foundry centers, Kelty Mental Health, part of the Children's Hospital, and virtual supports). There is no mention of the provincial Integrated Child and Youth Teams (BC/MMHA, 2022), BC/MCFD mental health supports for youth, or how to access these types of additional pathways to support. Similarly, although the FNHA is committed to providing enhanced supports for youth (2021), this stakeholder is not a direct partner. The SACY *Substance Use Prevention Initiative* is featured prominently on the VSB website among supports prevention initiatives and school/parent supports in connection with the VCHA and Vancouver Police. That is, though symbolic policies in favour of increased community services

and interdisciplinary responses seem to be supported by material actions, there is not an emphasis on single access points as was featured in some of the Winnipeg policy actions context.

Discourses of coordination. I coded for the presence of coalitions, evidence of vertical or horizontal coordination, the level of coordination and opportunities for and barriers to coordination in the regional subsystems. Themes uncovered are presented in Table 5.18.

Table 5.18 Coalitions, Types of Coordination and Barriers to Coordination in Regional (BC) Documents

Discourses of Intent *Stakeholders and Timelines Involved in the Discourse*	**Policy Actor Supporting this Discourse - of-Intent**	**Coalitions – existing partnerships with policy actors** **(By Policy actors)**	**Opportunities or Barriers to coordination** **(By policy actor)**		
			Evidence of Vertical or Horizontal Coordination	**Low level service coordination or policy integration**	**Key Opportunities and Barriers:** • **Shared Values/Lack of Shared Values (SV/LSV)** • **All Policy Actors Present (APAP)/ Not Present (PANP)** • **Fidelity Implementation (FOI)/ Lack of Fidelity (LFI)** • **Funding Decisions at Same Level (FDSL)/ Different Levels (FDDL)**
Service Provision for MHSUD *RBC1, RBC3, RBC5, RBC6,*	**VCHA**	**Provincial** • Center for Addictions Research **Regional** • Vancouver School Board • University of British Columbia • Vancouver Police Department • SACY: Substance Use Prevention Initiative	Horizontal – work with regional partners	Policy Integration and Service Coordination	SV, PAP • Shared focus on youth MHSUD – VSB, Vancouver PD, VCHA have shared strategic plans including tiered interventions. FDSL • Shared interventions, partnerships, and staffing to support (ie – District Principle of MH), funding from VCHA, funding from police PANP • Not reference to or overlap with CFD mental health supports for youth • Document predates Integrated Child Youth Teams
	FNHA	**Provincial** • Tripartite Committee on First Nations Health • First Nations Health Council • First Nations Health Directors Association • Indian Residential Schools Resolution Healing Program	Vertical – work only with First Nations led organizations	Service Coordination	SV • Shared values with First Nations health directorate in concert with Province of BC, federal government to support autonomous service provision for First Nations.
	PHA	**Provincial** • Ministry of Health • Correctional Health Services **Regional** • Private service providers for MHSUD, including: transitional housing, virtual health care supports • Regional Health Authorities	Horizontal	Service Coordination	PAP • PHA works to gather private and regional service providers in order to determine treatment placements for patients with intensive needs FOI • Data-informed decisions to place individuals with intensive needs – work to provide single access point to multiple provincial and NGO services
	VSB	**Provincial** • School personnel **Regional** • Service providers: Foundry Centers, Kelty Mental Health – BC Children's Hospital, virtual mental health supports	Horizontal	Service Coordination	PANP • VCHA documentation indicates referral services in partnerships with the VSB for youth referrals. This partnership not mentioned here. • CFD therapy supports not mentioned here • ICY Teams not mentioned
Minimize harms from MHSUD by treatment as a cross-sector issue. *RBC2, RBC4, RBC7*	**VCHA**	**Federal** • TRC **Provincial** • Ministry of Health • Ministry of Mental Health and Addiction	Vertical – service provision	Service Coordination	PANP, LSV • Sites "interdisciplinary teams" (2021, p. 18) but really centered in medical supports. • Reference to community care does not site partnerships with schools or social supports (2021)
	FNHA	**Provincial** • Province of BC	Vertical— service	Service Coordination	PAP, SV

		• First Nations Health Council • First Nations Health Directors **Regional** • First Nations Communities in BC	provision to First Nations communities		• Shared values with First Nations health directorate in concert with Province of BC, federal government to support autonomous service provision for First Nations (2021) • Feedback from First Nations communities informs direction (2021)
	VSB	**Provincial** • Center for Addictions Research **Regional** • Vancouver Coastal Health Authority • University of British Columbia • Vancouver Police Department	Horizontal	Policy Integration and Service Coordination	SV, FDSL • Shared focus on youth MHSUD – VSB, Vancouver PD, VCHA have shared strategic plans including tiered interventions (2023b) • Shared interventions, partnerships, and staffing to support (ie – District Principle of MH), funding from VCHA, funding from police (2023b) PANP • Not reference to or overlap with CFD mental health supports for youth • Document predates Integrated Child Youth Teams
Safe Schools *RBC8*	**VSB**	**Provincial** • Ministry Child and Family Development **Regional** • Vancouver Police Department	Vertical – directive to school sites	Service Coordination	PANP, LSV • Though reference to restorative responses, disciplinary document does not reference social and health-based interventions cited elsewhere in the VSB data set; disciplinary response ignores service providers and existing pathways as part of SACY initiative, for example (2023c) • Treatment of MHSUD here supports a different vision than elsewhere in the VSB data set (2023a)

In the Vancouver policy subsystem, the VSB and VCHA co-launched a Supporting and Connecting Youth (SACY), *Substance Youth Health Prevention Initiative* in 2017. This initiative shows evidence of shared vision and planning horizontally—with all policy actors at the table, including Vancouver Police—and also vertically in keeping with the *Mental Health in Schools Strategy* (ME, 2020). With a shared focus on youth MHSUD, the VSB, Vancouver PD, and VCHA all have shared strategic plans related to the strategy, including tiered interventions (2023b). These shared interventions include partnerships, staffing allocations (for example, a District Principal of Mental Health in the VSB), funding from the VCHA, and funding from police (2023b).

However, the coordination required to coordinate multiple partnerships and policy actors also results in some barriers to coordination. Regional actors do not cite service provision frameworks implemented provincially (for example, BC/MCFD's mental health supports for youth and BC/MMHA's Integrated Child and Youth Teams), suggesting that there may be some variation in the way these actors fit into regional frameworks. At the regional level, we see stronger horizontal partnerships between health and education than we do social services and education. Furthermore, although there is reference to restorative responses in the VSB's disciplinary documents, they do not reference social and health-based interventions cited elsewhere in the VSB data set. That is, disciplinary responses ignore service providers and existing pathways as part of SACY initiative (SACY, 2023). The fact that disciplinary policies do not align with support-based and therapeutic policies suggests that different coalitions with competing values may also clutter this particular landscape.

Coordination and collaboration with Indigenous communities and TRC Calls to Action. In the BC context, the discourse of intent of service provision was found to be rooted in

stronger iterations of culturally responsive service provision than the Manitoban subsystem. For example, by working to provide "culturally safe and trauma-informed cultural, emotional and mental health services" (FNHA, 2023, p. 1), there is reference to service provision outside a Western clinical model. Whereas Manitoban documents reference socio-ecological contexts, the role of colonialism is less overt in the Manitoban documents than in the BC documents. In BC, the First Nations Health Directorate in concert with Province of BC and the federal government, have developed a framework to support autonomous service provision for First Nations (2021). In this framework, feedback from First Nations communities informs direction (2021), and First Nations health authority in BC serves to bring these issues of reconciliation to the surface. It is evident from the analysis that the FNHA partners with federal stakeholders (for example, Government of Canada and First Nations Health Council) and with Province of BC to ensure funding for Indigenous youth includes culturally reflective treatments, substitution therapies, harm reduction strategies, harm reduction, and online resources. Though funding decisions are made at different levels, the FNHA ensures that there is service provision with access to grass roots services, where multiple funding sources work together to meet outcomes specific to the *Planning for Hope* (2018) document.

Key takeaways: BC regional data set. In the data set examined in the BC regional data set demonstrates service provision as a primary discourse of intent across policy actors and sectors. However, in contrary to the Manitoban data set, this service provision mandate is supported by a shared understanding of socio-ecological models of health. Therefore, where the Manitoban context seems to employ coordination-via-consolidation, coordination-via-proliferation and the creation of interdisciplinary teams is seen in the BC data set. Put simply, the data set shows that, where the Manitoban policy-system has contracted to support coordination,

the BC regional jurisdiction has multiplied services to support coordination. This multiplication of services via interdisciplinary teams includes policy actions rooted in tiered continuums of responses to MHSUD in schools, including the presence of regional (for example, VSB, VCHA, Kelty Mental Health, and Foundry Centers) and provincial (for example, BC/MH and BC/MCFD) actors in the policy system. The tiered policy actions in schools include prevention and counselling initiatives (VSB, 2023), health-based service provision (VCHA, 2023), counselling services (BC/MCFD, 2020; VSB, 2023), interdisciplinary youth teams (BC/MH, 2023), police supports (VPD, 2023), and access to intensive services (BC/MH, 2023). However, as noted, this burgeoning of supports includes some murkiness with regards to where these policy mandates begin and end, and thus, there is a danger that service navigation in a denser system may be difficult for youth and families to navigate. From a coordination perspective, the BC jurisdiction provides a promising practice for Manitoban consideration with regards to engagement and meaningful collaboration with Indigenous groups. Formal governance models co-established with the FNHA and First Nations Health Directorate provide exemplars that prioritize Indigenous voices, cultures, and positioning in program mandates related to MHSUD.

Summary: Government-Affiliated Stakeholders

In this section, I have reviewed and identified documents from federal, provincial and regional stakeholders in the Manitoba and British Columbia policy subsystems of MHSUD. For each level of governance, I conducted a CDA in service of a Stakeholder Analysis by coding to identify discourses of intent, action, and coordination that are inherent in policy documents. In the next section (5.3), I explore documents developed by non-governmental actors in response to the governmental policy positioning explored in this section. In chapter 6, I analyzed the data

presented in response to the primary research question: How can policy coordination be utilized to improve multi-sector support for youth with MHSUDs in Manitoba schools?

Non-Governmental Stakeholders

As indicated in the Methodology chapter, I examined discourses in the non-governmental documents differently than the governmental documents because these policy documents (and the policy actions within them) are positioned in response to the governmental actions of policy subsystems. In order to analyze data in the non-governmental data set, for each document I collected signifiers reflecting: (a) the stakeholders represented in the document and the positioning of the policy document (for example, what is the document responding to); (b) the existing policy subsystem intents, actions, and coalitions represented; (c) critiques of existing policy intents, actions, and coalitions; and (d) recommendations made. In an attempt to consider the ways that non-gorenmental actors contribute to policy influence and learning, I examined themes relating to the policy interests and beliefs, actions, and coalitions that these actors affirm, critique, and recommend in the subsystems to influence policy learning and change.

Identified NGO: Mental Health Commission of Canada

As per the inclusion criteria, I examined documents from the Mental Health Commission of Canada (MHCC) from the last 10 years with a mandate to inform youth MHSUD policy. The MHCC was selected for its role as the cross-national NGO for examination. In total, this included seven policy documents from the MHCC. Table 5.19 outlines the data on policy actors and stakeholder positionings for each NGO document examined. The table also identifies values, policy actions and coalitions and provides critiques available. Documents coloured yellow represent news stories publicizing emerging and current governmental values, actions or coalitions. Documents coloured purple indicate documents critiquing existing governmental values, actions or coalitions.

Table 5.19 Critiques of Intents, Actions, and Coalitions and Recommended Strategies in Examined NGO Documents.

Critiques of existing values, strategies, and coalitions in the existing subsystem of youth MHSUD responses				
Docu-ment #	**Stakeholder(s) represented** *and positioning of the document*	**Existing policy subsystem** actions and coalitions represented **(I)=Intents** **(A)=Actions** **(C)= Coalitions**	**Critiques of existing policy subsystem** actions and coalitions **(I)=Intents** **(A)=Actions** **(C)= Coalitions**	**Strategies and coalitions recommended**
NGO1	The Time is Now: Considerations of a National Psychotherapy Program (2022) **MHCC** *following an agreement between Health Canada and MHCC to develop a plan for increasing Canadian access to psychotherapy*	**(A)**In Canada, public funding covers psychotherapies delivered in hospitals, by physicians, or in community services. These services generally have long wait lists. **(A)**Services by non-physicians (psychologists, psychotherapists, nurses, occupational therapists, social workers) not covered by public funding.	**(I)**Currently a lack of parity for physical and mental health **(A)** MHSUD services are not eligible for public funding unless the service providers are working in hospitals or in community settings funded by government, their services are not eligible for public funding.	Recommendation to find pathways to publicly fund psychotherapy via one of two funding models: 1. provider based: allocate fixed amount to provinces to expand coverage for mental health "earmarked for health care provides who may not be currently reimbursed" 2. program based: allocate a fixed amount of funding to a program that expands psychotherapy options Further recommendations include: development of quality standards especially for those with access issues, integration of national psychotherapy program to existing local care pathways, regular data samples to ensure data-based decisions and evidence-based practice.
NGO2	Stepped Care 2.0 (2021) **MHCC**, *following a partnership with Newfoundland, establishing a multi-tiered system of supports for MHSUD.*	**(A)**The MHCC presents concerns with the lack of access to mental health care in Canada in general. It looks at Newfoundland/Labrador in particular.	**(A)**Based on the model developed and implemented in the U.K., stepped care offers an evidence-based, client-centred stage system of care that prioritizes the most effective and least intensive treatment. **(A)**Tiered responses consist of rapid access single session clinics, recovery-oriented treatment principles, e-mental health programming with each step.	• Stepped Care 2.0 is a promising model for integrating e-mental health interventions, recovery principles, and single session rapid access counselling with traditional (or established) in-person programming on a provincial scale. • Large-scale implementation of Stepped Care 2.0 and e-mental health at the provincial level requires dedicated staff positions, including a provincial project lead, site implementation managers (e-mental health managers), dedicated trainers and cross-site training.
NGO3	Combatting Mental Illness and Substance Use Related Structural Stigma in Health Care – A Framework for Action (2020) **MHCC**, *following continued concerns about stigma in MHSUD care.*	**(A)**Evidence of systemic failure to for MHSUD including: inequitable distribution of resources, undertreatment of physical health issues for those with substance use issues, withholding of services for those with substance use issues, and the fragmentation of care. **(I)**People with lived experience tend to systematically receive a poorer quality of care for both their physical and mental health needs.	**(I)**Training interventions are not enough; practitioners' attitudes and behavioural intentions do not change over time if they are not implemented widely and thoroughly, and not sustained.	Dedicated work to improve attitudes and practices of health-care practitioners and other system stakeholders while focusing on change at both individual and cultural levels • strengthen the integration and coordination of care • achieve equity in resource distribution for mental health and substance use services and research • expand access to effective treatment • establish mechanisms to monitor structural stigma • foster the meaningful inclusion of people with lived experience • enhance and enforce protections.
NGO4	Strengthening the Case for Investing in Canada's Mental Health System (2018) **MHCC** *following mental health deemed*	**(A)**7.2% of Canada's total health spending is on mental health, below G-8 peers. The current system is wrought with unmet needs, system pressures and long wait times.	**(I)**MHCC argues that it is vital to clearly demonstrate how provinces and territories can bolster their bottom line while improving mental health outcomes.	Investing in mental health promotion and early intervention are identified as areas that can stem the tide of economic losses. Exemplars include: • community-based rapid-response teams; • improving access to psychotherapy;

	a priority in the health accord, but with continued concerns about health care spending.	Costs and harms of MHSUD include economic, health related, social implications, vocational implications.	**(A)**Exemplars of 9 provincial programs with evidence-based reduction in costs/harms are provided.	• offering one session of counselling for high users of emergency rooms; • offering people on short-term disability timely collaborative care (between family physician, disability case manager, consulting specialist)
NGO5	Funding Expanded Access to Psychological Interventions (2017) **MHCC** *following lack of action regarding psychotherapy public funding following the 2012 Mental Health Strategy for Canada*	**(A)***The Mental Health Strategy for Canada* advanced two recommendations to enable wider and more equitable access to counselling, psychotherapy and psychological services for mental health problems and illnesses: (1) Increase access to clinical counselling by service providers;(2) Remove financial barriers for children and youth and their families to access psychotherapies/ clinical counselling.	**(A)**There are two ways in which public money finds its way into the hands of providers to pay for their services: 1) A provider works for an organization that receives government funding (hospital, clinic, agency) and is paid directly by that organization. 2) A provider works as a professional who bills government directly.	Recommendation to pursue governmental support of broader public psychotherapy coverage.
NGO6	Substance Use and Suicide Among Youth: Preventions and Interventions Strategies (2017)	**(I)** Current standard of care is to treat substance use and suicidal behaviour separately even though concurrent treatment is evidence based.	**(A)**Youth with co-occurring issues referred to separate addiction and mental health systems are less likely to receive proper treatment. **(C)**Lack of collaboration between addiction and mental healthcare systems places a burden on an individual.	Increased awareness and training for health care providers to reduce redundancy needed. Two gaps identified: • Need for better promotion of integrated treatment for mental health, substance use and suicidal behaviours. Need to enhance awareness of this co-occurrence to encourage people to access healthcare services if they or those they know have these problems.
NGO7	School-Based Mental Health in Canadian Schools (2013)	n/a	**(C)**There is a lack of integration and common vision across initiatives doe MHSUD in Canadian schools. School divisions in Canada do not have the organizational conditions in place to deliver coordinated, evidence-based strategies across the continuum of care. **(A)**While division teams are growing and beginning to develop policies, infrastructure for effective school mental health is lacking (e.g., protocols for decision-making, systematic training, role clarity). Respondents indicated that the emphasis in boards continues to be on intervention services for high needs students, rather than on mental health promotion and prevention. **The full continuum of care is not being addressed in a proactive, even manner.**	Universal programs ought to be implemented in consistently in Canadian schools as a means to improve the wellbeing of children and youth. Social skills training or social emotional learning should be implemented universally to bolster student coping ability and to develop resilience to emotional and behavioural problems. School-based behavioural and cognitive-behavioural programs, designed to prevent problems with aggression and conduct can be effective in reducing symptoms. For these externalizing behaviours, the best approaches focus on prosocial skill development, conflict resolution and anger. The field is calling for more professional development for educators, particularly in relation to mental health promotion and prevention, recognizing signs and symptoms of mental health problems, and engaging families.

As demonstrated in Table 5.19, the MHCC creates policy documents in response to political changes (for example, via commissions from the HC on funding and mental health's inclusion in the health accord) and new research (for example, on stigma, treating comorbid conditions, or case examples of effective programming). In all seven documents examined, the primary discourse of intent was increasing access to MHSUD supports. MHSUD is framed as a public health issue, positioned as an extension of physical health systems (for example, advocating for funding parity for physical and mental health [MHCC, 2022]) and as a socio-ecological health issue, with understandings of a wide range of harms and cross-sector responsibility (for example, by broad harms/costs and cross-sector responsibility for MHSUD as responsibility of governments (MHCC, 2018). It is noteworthy that MHSUD is framed as a public health or biomedical issue only in the documents dealing with funding, as the funding model suggested involves improvement of transfer-payment programming from HC to provincial models of health. In all other documents, MHSUD is framed as a cross-sector issue of harms requiring cross-sector and multi-tiered supports.

Analysis of this data set highlights some key value positions inherent in the MHSUD policy subsystem and highlighted by the MHCC documentation. For example, the need for the MHCC to argue for mental health supports to be treated with parity alongside physical health (MHCC, 2022) suggests that mental health is still not given the same weight in health care conversations as physical health. This is echoed in the MHCC's advocacy to continue work combatting systemic stigma in care systems (MHCC, 2020) and the fact that the MHCC continuously uses budgetary information to bolster arguments about the need for additional supports for MHSUD. For example, the MHCC argues that provinces can lower spending as an impetus to investing in mental health outcomes (MHCC, 2018). Furthermore, the MHCC spends

considerable time discussing the need to treat mental health and substance use concurrently, arguing that individuals with substance use receive poorer care as a result of their lived experience. This positioning in advocacy suggests that there exist policy actions which underscore beliefs of MHSUD as less-deserving of funding than physical health with the problem located within individuals themselves.

Reflecting on the existing landscape, the MHCC has made recommendations for policy actions in the form of symbolic policy actions with specific advocacy to:

a) Systemically increase funding or access to funding for psychotherapy in the Canadian health system (MHCC, 2022);
b) Ensure that MHSUD supports are offered via a continuum of multi-tiered services with quick access points (MHCC, 2021);
c) Continue stigma reduction campaigns for MHSUD (MHCC, 2020);
d) Remove treatment redundancies for MHSUD (MHCC, 2017); and
e) Support a country-wide implementation of a continuum of tiered services for MHSUD in the school system (MHCC, 2013).

In order to achieve these recommendations, the MHCC advocated for increased vertical coordination between HC and provincial ministerial legislation to ensure that mental health funding is publicly funded in a similar manner to physical health funding (MHCC, 2021). In terms of horizontal coordination, the MHCC calls for greater consistency at provincial and regional levels in terms of continuums of services offered in schools from province to province (MHCC, 2020) and for regional service providers to work together to reduce redundancies in triaging and care (MHCC, 2017).

Key takeaways: MHCC. The MHCC analysis highlights that despite multiple sector funding for MHSUD at the provincial level, the primary funding mechanism for MHSUD funding at the federal level is through transfer payments by Health Canada. This demonstrates that despite documented efforts in the last 5-10 years to consider MHSUD as a socio-ecological health issue with multi-sector responsibility and the need for policy coordination, the federalist system confines many of these conversations to the health care system by virtue of existing funding pathways and structures. Furthermore, even considerations of MHSUD as a health care issue seem to be held back by stigma and considerations of MHSUD as subordinate to physical health. When we consider then, the evolution in discourses seen federally and provincially over time with MHSUD considered a safety issue, then a health issue, and more recently a socio-ecological health issue. The policy advocacy put forward from the MHCC indicates that there is not yet consistency in terms of commitments to holistic policy actions. Actions remain shackled at the funding level without consistency to enhance collaborative relationships to support MHSUD across sectors. MHCC seems to be responding to a policy subsystem in which advocacy for health care funding for MHSUD and advocacy for cross-sector collaboration for MHSUD are both still mired in discourses of funding and stigma for MHSUD. That is, this analysis identifies both the lack of shared values regarding MHSUD nationally and the ways in which the federalist model as is has been implemented thwart holistic and socio-ecological responses to MHSUD in provincial jurisdictions.

Media - Manitoba

As per the inclusion criteria, I examined print media from the Canadian Broadcast Corporation (CBC) from the last 10 years dealing with issues around youth substance use and

youth mental health, drawing from the CBC online search engine. In total, this included 20 print media documents from the CBC in the Manitoban media subsystem. Table 5.20 outlines the policy actors and stakeholders who have voice in each of the articles. This collection of data allows for analysis of what policy actions are being covered in the media, identification of themes in the media as a means to gauge community values, and consideration of critiques/recommendations of the policy subsystems that have been investigated in the previous sections. In Table 5.20, articles coloured yellow represent news stories publicizing emergent and current governmental values, actions or coalitions. Articles coloured purple indicate news stories critiquing governmental values, actions, or coalitions.

Table 5.20 Stakeholders, Interests, Policy Actions, and Coalitions in the Media Sample for the Manitoba MHSUD Policy Subsystem

Critiques of existing values, strategies and coalitions in the existing subsystem of youth MHSUD responses				
Document # (year)	**Stakeholder(s) represented** and positioning of the article	Existing policy subsystem actions and coalitions represented **(I)=Intent (A)=Actions (C)= Coalitions**	Critiques of existing policy subsystem actions and coalitions **(I)=Intent (A)=Actions (C)= Coalitions**	Strategies and coalitions recommended
MM1 (2022)	**Manitoba Psychological Association**, **Canadian Alliance on Mental Health, Province of Manitoba** *following concerns raised by psychologists with staffing and funding shortages for psychologists in Manitoba*.	**(A)Province of Manitoba** says building capacity with staffing a primary goal, currently lowest psychologists per capita	**(A) Canadian Alliance on Mental Health** recommends provinces spend 9-12% of public health funding on MHSUD. **Manitoba Psychological Association** argues that existing MHSUD treatment has "staffing shortages, lengthy waitlists and a system that is difficult to navigate".	• Increase public health funding to MHSUD • Hire and retain MHSUD staff, especially psychologists • Virgo Report 125 recommendations – only 7 fully addressed
MM2 (2022)	**Government of Manitoba, Mental Health Professionals** following Release of MMHCW *Pathway to Mental Health and Community Wellness*.	**(A) Government of Manitoba c**ommitments to: improve MH care, system accessibility, Indigenous initiatives.	**(A, C)** Concern that there is a lack of specifics on how government will accomplish broad goals, especially those cross-sector in nature (Mental Health Professionals).	• Development of a strategic plan with actionable goals
MM3 (2021)	**Manitoba Advocate,** following the *Listening Tour* with the Advocate Office.	n/a	**(I)Manitoba Advocate** argues youth not feeling supported in existing policy subsystem for youth MHSUD in Manitoba which they argue is not accessible and which denies eligibility for treatment.	• More MHSUD programs for youth • Reduce wait times
MM4 (2020)	**Manitoba Advocate, Government of Manitoba** following Advocate's concern regarding lack of action from provincial government on MHSUD youth.	**(A)Government of Manitoba** indicates it is working to improve youth MHSUD services: • Investment in NorWest Youth Hub for MHSUD counselling. • Expansion of trauma services at Klinic Community Health, The Laurel Centre. • Establishment of an inter-disciplinary team led by Aurora Family Therapy Centre to provide longer-term services for newcomers and refugee • Enhancing access to MH assessments and treatment at Children's Hospital.	**(I, A) Manitoba Advocate** indicates "Manitoba is dragging its feet when it comes to mental health and addictions supports" and that Manitoba Health has made the least progress implementing any of the 23 recommendations from the Advocate's Office between March 2018 and the end of December 2019; only 25% of recommendations had seen action.	• "One of the most immediate needs is the need for a very comprehensive plan on the implementation of mental health services across the province," – Manitoba Advocate
MM5 (2020)	**Manitoba Advocate**, **Health Minister**, following an Advocate report on gaps in the MHSUD system	**(A)Health Minister** Cameron Friesen said his government has made investments of more than $25 million on initiatives aimed at improving MHSUD services for youth, including $4.4 million to improve school-based mental health and addictions supports and $4.2 million for assessments and treatment.	**(A, C) Manitoba Advocate** Report *The Slow Disappearance of Matthew* showed that "the patchwork of mental health interventions he was offered were not well co-ordinated and did not help him recover" – Manitoba Advocate	• Need for access to long-term in-patient care, in Manitoba • Need a fulsome plan for MHSUD supports province-wide
MM6 (2019)	**Province of Manitoba,** following a funding announcement	**(A)**$4.2 million dollars in new funding will be put toward increasing access and availability of	**(A)**The number of youth seeking treatment for MHSUD has increased and he hopes boosting	n/a

		psychiatric nurses and other services for youth over the next three years.	staff and services will allow early intervention before problems become more serious.	
MM7 (2019)	**Manitoba Advocate, Indigenous Services Canada, Government of Manitoba Indigenous Leaders, Ma Mawi Wi Chi Itata (Indigenous resource center)**, following the death of Tina Fontaine in Manitoba.	**(V)Indigenous Services**: government is working with First Nations to further culturally minded solutions to mental health and addiction. **(A)Jordan's Principle** working to ensure funding for service provision for youth. **(I)**Memorandum of understanding between federal government and Manitoba Keewatinowi Okimakanak committing to First Nations run health care in northern communities. **(A)Federal** provision of services cited: suicide and substance use prevention online chat, community programs such as the *Native Alcohol and Drug Abuse Program*. **(A)Provincial Government** indicates "Virgo Report recommendations are underway that will remove barriers and make for more integrated, coordinated care options across the province".	**(A)**Unstable funds from federal and provincial governments for Indigenous- led MHSUD supports. **(I, C) Ma Mawi Wi Chi Itata** argues that reports from Virgo and the Children's Advocate failed to adequately consult with Indigenous communities on how to accomplish the recommendations they make.	• "We need to treat the family as a unit and we need to involve youth with elders and elders with youth, and we need to treat communities," Dr Fowler – Director of education for Ongomilzwin, Indigenous Institute of Health and Healing at University of Manitoba. "This is a very Indigenous-focused world view, because we don't think in silos — we think beyond ourselves • Healing centered Indigenous traditions like smudging, sweat lodges, access to traditional healers need to be supported financially and given priority as a first resort, not a last resort. .
MM8 (2019)	**Manitoba Advocate, Ma Mawi Wi Chi Itata** (Indigenous resource center), following report calling for legislation for confinement of youth.	**(A)** Youth Addiction Stabilization Act supports stabilization of youth for up to seven days. **Manitoba Advocate** calls for an extension in extreme cases	**(I, A) Ma Mawi Wi Chi Itata** argues there ought to be a continuum of services and that existing policy landscape does not have enough tiered interventions and supports in place.	• Alternative programming options to be considered are healing centers, where youth can access traditional teachings and supports not in a medical facility.
MM9 (2019)	**Manitoba Advocate** report on youth in care with MHSUD concerns	n/a	**(I, A)** Increases in drug use have not been paired with increases in services. Programming options available often deny eligibility for youth with profound needs. "Apart from short term detox services, there aren't any recovery programs taking in kids with the most severe substance use disorders, including addiction to methamphetamine" – **Manitoba Advocate**	n/a
MM10 (2018)	**Winnipeg Police** following death of Tina Fontaine	n/a	**(A)** Call to develop legislation to "lock up" runaway youth to stabilize and keep them safe.	n/a
MM11 (2018)	**Manitoba Advocate** following perceived lack of action following the Virgo Report	**(A) Manitoba Advocate** indicates that it offered decades of data to the Virgo Report which they turned down. Data was not included.	**(I) Manitoba Advocate** argues youth are dying from drug overdoses while the province remains mired in "Ideological debate about children". Current supports for MHSUD have restrictive admissions criteria that prevent young people from getting treatment.	• Development of "a concrete plan of action for youth mental health and addiction" – Manitoba Advocate • Early intervention services with a continuum of services are vital.
MM12 (2018)	**AFM** following funding announcement cutting programming at in-patient treatment program	**(A)** 6-week inpatient treatment program for youth being cut due to 2.7 million dollar shortfall. Program not at capacity; youth care not affected.	n/a	n/a

MM13 (2018)	**University of Manitoba research team,** following report linking bullying with substance use.	n/a	**(I)** Strong relationship between bullying victimization and drug use	• Should be starting preventative and skill-building programming prior to grade 7
MM14 (2018)	**Aboriginal Youth Opportunities** (local advocacy group) following perceived need for youth with meth addiction	n/a	**(A, I)** There is a very small window when someone is coming down from meth that they want to engage with support. But most organizations will turn you away if you are under the influence.	• Increased funding to community-run, community-referenced programs which meet youth where they are at
MM15 (2017)	**Manitoba Advocate**, **Health Minister** following documented rise of crystal meth use in youth	**(A)** Only detox service for youth is Youth Addiction Stabilization Unit with 4 voluntary and 4 involuntary beds. **Health Minister** indicates "Manitoba continues to invest in addictions services and work is underway to develop a mental health and addiction strategy".	**(A)** Limited resources for youth seeking help. Waitlists do not work as active addiction pulls youth back in quickly and responses are needed right when the youth reaches out.	• Increased resources for youth seeking supports • Continuum of responses needed
MM16 (2016)	**Behavioural Health Foundation,** following potential closing of youth programming due to funding.	**(A)** Manitoba government indicates it funds the Behavioural Health Foundation at 5 million per year.	**(I)** Programming for youth with comorbid MHSUD with trauma histories requires long-term treatment; 4-6 months to "assist these kids and really get them back on their feet". **(A)** Numbers of youth accessing the program are in decline "overworked social workers don't want to go through the lengthy process of getting youth placed in Behavioural Health Foundation facilities"	• Call to investigate need for these programs, refer youth and fund programming
MM17 (2016)	**Youth Worker**, in response to death of youth	n/a	n/a	• Parents need to talk to their kids about substances and try all available supports
MM18 (2017)	**Former gang member**, in response to death of Tina Fontaine	n/a	n/a	• Needs to be more education in schools about what can happen to youth • More safe places and resources for youth
MM19 (2017)	**Former student,** presentation on drug use in Manitoba schools	n/a	**(I, A)** Not enough education around addictions or enough supports for youth with drug involvement in schools.	• Schools in key position to support youth with drug use and more needs to be done to "rid our schools of drugs"
MM20 (2019)	**Parents of youth** after City of Winnipeg Meth task force does not include parental perspectives in task force	**(A)**Winnipeg Task Force on Meth included WRHA, provincial and city representatives and non-profit organizations. Task force made 24 recommendations including: safe drop-in centers, needle distribution, expansion of drug treatment court, creation of long-term treatment opportunities.	**(I, A)** Parents indicate their youth accessed existing treatment options in Manitoba, including the only long-term option (28 days) through AFM and youth relapsed every time; the resources did not support them, or their children, and they sought resources out of province at significant personal expense.	n/a

Themes Identified–Discourses of Intent, Action, and Coordination. In general, media reports in this data set centered around reporting about policy actions, specifically government actions to deal with youth MHSUD and critiques of those actions. Throughout the data set, a predominant discourse of intent was one of ensuring appropriate service provision, where MHSUD was framed as a health issue, a safety issue, a social issue, and an educational issue. In the critiques of policy actions, some key themes related to value-positioning of youth MHSUD emerged. I coded value statements and signifiers where values about youth MHSUD were drawn into question. In particular, a consistent theme of youth being disqualified from programming (evident in documents, MM5, MM8, MM9, MM11, MM14, MM16, MM20) centered around denied eligibility based on indicators such as being under the influence (MM14), having mental health concerns in addition to substance use concerns (MM9), having the wrong type of mental health concern (MM20), not having appropriate paperwork filled out (MM3), and social concerns, including school attendance (MM7). In terms of the values represented, this data set suggests that instead of ensuring that the policy subsystem invests in services that meet the needs of youth, there is an inherent value judgement about the types of youth who are able to access services. This is perhaps indicative of what MACY has called an ideological debate about the types of services that should be offered (MM11). Concerns about a lack of collaboration with Indigenous communities to offer a continuum of culturally informed practices (MM7, MM8) and a lack of cross-sector collaborative strategic planning offer similar concerns that there may not be alignment in terms of who the policy system is meant to serve versus whose needs it is actually meeting.

As noted above, the bulk of media's representation of, and critiques of, this policy subsystem is in the form of reporting on policy actions. In terms of critiques of policy actions, a

dominant theme in the media data set included critiques of policy actions limiting access for youth to supports. Of the 20 articles examined, 14 of them have to do with concerns about access to MHSUD supports for Manitoban youth. This included concerns with staff shortages and waitlists (MM1, MM3, MM15), lack of a strategic plan to streamline a continuum of services for youth (MM4, MM5, MM8), unstable funding federally and provincially which limit continuity of Indigenous-led programming (MM7), concerns with restrictive admissions which turn youth away rather than offering support (MM9, MM11, MM14, MM16), and shortages of programming (MM18, MM19, MM20). Concerns about access to services, appropriate types of services, culturally responsive services, funding for services, and continuums of services for different levels of needs and different access points are prominent throughout this data set.

In terms of coordination, this data set draws concerns with the lack of clarity in the Manitoban strategic plan for MHSUD, including how cross-sector collaboration will actually take place in absence of clear objectives or directives (MM2). Furthermore, concerns are raised with the lack of coordination between MHSUD services in the health care sector (MM4), lack of coordination with Indigenous groups for policy implementation (MM7, MM8) and lack of consultation with the Advocate's Office in the Virgo Report (MM11).

A Storyline of Control. As discussed in Chapter 3, Auld and Morris (2016), argued that two broad storylines are employed in policy to support actions and change: stories of decline, which provide impetus for reform; and stories of control, which are intended to inspire faith that the right actions are being taken. In both contexts, policymakers create narratives that support arguments either for changes to the existing policy landscape, or to continue with existing policy models. In the case of the media representation in the Manitoban policy sub-system of MHSUD, we see a similar pattern in the examined documents, in which there is a concern raised about the

efficacy of MHSUD programming in Manitoba (generally raised by the advocate or a local service provider), supporting the storyline of decline. This is followed in most cases by a statement from the provincial government outlining what policy actions have already been taken and reassuring the reader that the policy problem is under control, supporting the storyline of control. In every media article which a representative from the Government of Manitoba is a source, this storyline of control follows a predictable pattern of calls by community members, service providers, professional organizations, or MACY to re-evaluate and reconsider service delivery frameworks or funding, followed by assertions from the provincial government that things are under control. Control-based discourses include reassurances that gaps are a short-term consequence of capacity building (MM1), that Virgo recommendations or the MB/MMHCW *Pathway* document will fix the problem (MM7), or that funding additions, investments, and expansions of existing programs are already in place (MM5, MM13, MM16, MM20).

A cog in the wheel of the storyline of control provincially seems to be a primary strategy by MACY to utilize the media to amplify findings and reports as a means to publicly call the government to task. A trend of government officials needing to respond to concerns raised by MACY to the media is seen through 2020 when Daphne Penrose was serving as Manitoba Advocate. The media portrayal then of MACY and the provincial government, appears as an adversative one, with government officials defending actions rather than agreeing with findings or committing to implementing recommendations.

Key takeaways: Manitoba media. Perhaps the key takeaway from the analysis of Manitoban media data set is the prominence of the theme of ensuring appropriate service provision for youth. The media data set highlighted and emphasized existing impacts of current

MHSUD service provision through interviews and reviews of policy actions from stakeholders including service providers, Indigenous advocacy groups, youth, parents, government officials, MACY, and professional organizations with interests in MHSUD service provision. The work that the CBC is taking on in highlighting barriers to appropriate supports for MHSUD is centered in a willingness to explore diverse responses to the policy problem of MHSUD. This seems to indicate a public willingness to support socio-ecological approaches to MHSUD as public goods, beyond simply discussions of public safety or health care systems, echoing value changes that were seen over the last decade in federal policy as well. A consistent theme in response to existing policies in the media data set was an exploration of the ways in which the current policy subsystem was not meeting the needs of youth. This included inquiries into a lack of available services, barriers to services, and places in which existing services did not align with youth needs and youth values. In addition, the analysis shows that the government utilized a storyline of control in response to advocacy and concerns raised.

Media - BC

As per the inclusion criteria, I examined print media from the Canadian Broadcast Corporation (CBC) from the last 10 years dealing with youth substance use and youth mental health as drawn from the CBC online search engine. I identified 20 print media documents from the CBC in the British Columbia/Vancouver subsystem for analysis. Table 5.21 outlines the policy actors who have voice in each of the articles. This collection of data allows for analysis of what policy actions are being covered in the media, identification of themes in the media as a means to gauge community values, and consideration of critiques/recommendations of the policy subsystems that have been investigated in the previous sections.

Table 5.21 Stakeholders, Policy Actions, and Coalitions in the Media Sample for the BC MHSUD Policy Subsystem

Critiques of existing values, strategies and coalitions in the existing subsystem of youth MHSUD responses				
Document #	**Stakeholder(s) represented** and positioning of the article	**Existing policy subsystem intents, actions and coalitions represented**	**Critiques of existing policy subsystem intents, actions and coalitions**	**Strategies and coalitions recommended**
MBC1 (2023)	**N'alaga Consulting** (addictions programming for treatment centres rooted in Indigenous knowledge and healing), **First Nations Health Authority (FNHA)**	**(A) FNHA** website lists 10 treatment centres in B.C. for those seeking addiction services. Despite these interventions, First Nations people were dying from illicit drug toxicity at five times the rate of B.C.'s general population.	**(A) N'alaga Consulting Health Lodge** is funded by the FNHA, Correctional Services Canada, grants and private donations, but there is limited capacity. As a result, access to elders, cultural teachings, land-based healing is limited capacity is low. People are put on waitlists, but with toxic drug supply, people are dying waiting for treatment.	• Need for increased land-based, culturally rooted, trauma-informed from Indigenous social justice lens treatment centres," she said.
MBC2 (2022)	**Directions Youth Services, Ministry of Mental Health and Addictions, Vancouver Coastal Health Authority (VCHA)**	**(A) MMHA** said funding is being reallocated. **(I) VCHA** said funding will go toward a withdrawal management model, as the social detox model doesn't align with addiction-treatment guidelines from the Ministry of Health and B.C. Centre for Substance Use.	**(A) Directions Youth Services** was told by the province that it will no longer fund its youth detox program. Advocates argue there are already few places for youth struggling with addiction to go. **(I, A)**Advocates say social detoxification model shows promise	• Advocates argue the need for social detox models and more treatment opportunities, not less.
MBC3 (2021)	**Last Door Recovery Society**	n/a	**(A)** Community approach with therapy, counselling, a balanced diet, recreation and socialization and post-treatment help with access to educational opportunities is helping clients.	n/a
MBC4 (2021)	**Vancouver Area Network of Drug Users (VANDU), Vancouver City Council** *following drug possession exemption in Criminal Code*.	**(A)** In November 2020, **Vancouver City Council** approved a motion exempting Criminal Code provisions on simple drug possession, laying the groundwork for what is now the *Vancouver Model*.	**(I)** VANDU argues the threshold levels are too low, meaning drug users would still be criminalized if the Vancouver Model comes into effect in its current form. The coalition is also critical of the involvement of the Vancouver Police Department (VPD) in the creation of the *Vancouver Model*.	• the goal of decriminalization should be to remove police from a policy initiative, not give them "considerable input." • Improved consultation with drug users.
MBC5 (2021)	**B.C. Minister of Mental Health and Addictions (MMHA), BC Social Liberties Office, Social Work Association** *in response to arguments that involuntary detention for youth not be used for overdose*.	**(A) MMHA** accepts recommendation to not use involuntary holds for youth with overdose. Declares a commitment to "partner ministries to review and develop a plan with Indigenous partners to address the recommendations and reflect them in ongoing work as we continue building a co-ordinated mental health and addictions system from the ground up".	**(I) Social Work Association** argues the need to "strengthen safeguards in the involuntary detention and treatment of youth within the mental health system [and] enhance opportunities for young people to have a say in their treatment." **(I) Civil Liberties Association** expressed concern, with the finding that more youth were receiving involuntary services than voluntary services.	• Calling on the B.C. government to amend the Mental Health Act to allow youth to have access to a legal advocate while they're in care. • Instead of involuntary holds, offer culturally responsive care
MBC6 (2020)	**MMHA, Advocate for Children and Youth, Pathways Serious Mental Illness Society, BC Children's Hospital, Pivot Legal Society** *following concerns about involuntary psychiatric holds for youth*	**(I) MMHA** is seeking further consultation on a bill that would allow youth to be involuntarily hospitalized for up to a week after they overdose.	**(I)Advocates for the program** say youth in hospital are cared for a week can build relationships with health practitioners who can help them transition back into the community. **(I) Representative for Children and Youth**, says the bill will deter youth from asking for help over fears they'd be forced into treatment, and because it disproportionately impacts Indigenous youth. **Parents** say they want the government to do more to compel young people to seek treatment when their rationality is hampered by addiction.	• Detaining youth in hospital is one part of a continuum of responses and recommendation is to continue developing other options alongside this debate.

			(I) Legal advocates say forcing people into treatment doesn't work	
MBC7 (2019)	**BC Coroner's Inquest** *report following death of a teen to opioid addiction.*	**(I, A)** Existing privacy laws restricted parents from receiving medical information to address their child's addiction troubles.	**(I)**Parent interviewed indicated that his child was not capable of making rational choices, yet medical system did not share information with parents. **(I)** Pediatrician interviewed stated that acceptance of voluntary youth drug treatment the "best possible situation" but wait times are "scandalous".	• Improved spectrum of resources for youth MHSUD • Alternatives to psychiatric holds which alienate youth from families • Changes to confidentiality policies
MBC8 (2018)	**Vancouver Coastal Health (VCHA), Vancouver School Board (VSB)** *regarding MHSUD education initiative*	**(A) VCHA, VSB** are helping prepare youth, parents and teachers with workshops and resources through their drug-prevention program called *Supporting and Connecting Youth* (SACY).	**(I)** Youth need to be seen as a resource to health discussion about drugs and alcohol, not a problem.	n/a
MBC9 (2017)	**Harm Reduction Advocates, Moms Stop the Harm, Ministries of Education (ME), Vancouver School Board (VSB), Vancouver Coastal Health Authority (VCHA)** *following concerns of a fentanyl crisis with BC youth*	**(A)**Provinces with significant fentanyl concerns have been updating their school programming to reflect the continuing crisis. **BC's ME** has added modules on overdosing to its curriculum, and several larger B.C. school divisions have programs dedicated to teaching about the risks of drug contaminants. **(A)**Partnership between **VCHA, VSB** is "the most extensive drug education effort in Canada". The program places emphasis on how to recognize and react to an overdose.	**(A)** Yukon is the only province or territory in Canada to have trained all its school administrators in how to use naloxone and to stock every school with a naloxone kit. **(I, A, C)** Training like the SACY program in the VSB isn't offered by smaller school divisions, which can't dedicate the same number of resources to educating youth about fentanyl and overdosing.	• Need for more consistency in drug education; currently there are "inequities and a patchwork" of harm-reduction, prevention and awareness initiatives in Canada. – representative for Alberta's School of Public Health. • School curriculum should be about focusing on social emotional learnings and building resilient youths.
MBC10 (2017)	**Icelandic Drug Strategy** *as a model for a drug strategy that could work in Vancouver.*	n/a	**(A)**Iceland combatted concerning substance use with state-sponsored recreational activities and after-school programs meant to enhance family ties and community bonds. Government and corporate messaging highlight the importance of family ties, and teens abide by late night curfews.	• Recommendation to look into this model in the Canadian (Vancouver) context.
MBC11 (2016)	**Substance Use Health Promotion, Vancouver School Board** *following legalization of marijuana*	**(I, A)** Drug abuse curriculum is changing to reflect the new reality. Key messages are delaying use, focusing on mental health, for youth that are using, cutting back on use. "	n/a	n/a
MBC12 (2016)	**Last Door Addiction**	**(I, A)** Last Door Addiction program ensures families are included and focuses on a social treatment model for substance use.	n/a	• Recommendation to increase programs and supports programs province-wide
MBC13 (2016)	**Panel Discussion from Canadian Center on Substance Use**	**(I)** Marijuana dangerous for youth, whose brains are still developing, high likelihood of dependency	n/a	n/a
MBC14 (2016)	**Psychiatrist, Child and Family Development (CFD)** *– on whether there are sufficient supports for youth MHSUD*	**(A) CFD** statement indicates that there are enough MHSUD resources for youth in BC.	**(I)** Services require that a youth wants to participate; the range of services available does not currently support all youth, and MHSUD services are not properly funded so families are paying out of pocket to get immediate or proper supports.	• Re-evaluate treatment needs

Themes identified: Discourses of intent, actions and coordination. In the BC media data set, the prominent discourse of intent, like Manitoba's, is centered around service provision. However, the BC data set seems to represent a policy subsystem wrestling with appropriate service provision for MHSUD through inquiries into different facets of MHSUD as a policy problem. Discussions take on MHSUD as an issue of reconciliation, discussing the need for culturally responsive care (MBC1); as a social issue requiring social and not just medical supports (MBC1, MBC12); as a legal issue related to decriminalization (MBC4, MBC13); as a moral issue looking at questions of whether we ought to remove free will from youth with MHSUD (MBC5, MBC6, MBC7); as a treatment issue highlighting a paucity of resources (MBC14); and as a prevention issue, by looking at schools' roles in primary prevention (MBC8, MBC9, MBC10, MBC11). I, thus, identified the primary discourse of intent in the media data set as seeking meaningful or effective treatments for youth MHSUD.

In terms of policy actions, critiques in this data set come from service providers (including: Last Door Recovery, N'alaga Health Lodge, Directions Youth Service, Moms Stop the Harm, alongside regional health authorities, hospitals, and school divisions) and citizens in the policy subsystem. There were calls for changes to drug laws and school systems to respond better to stakeholder needs (MBC9), the need for a continuum of supports and culturally responsive care with increased capacity (MBC1), and investigations into policy models which seek to control youth with MHSUD (MBC5). Recommendations include increasing land based and social treatment models (MBC1, MBC2), replacing involuntary care with appropriate continuum-based supports that meet the needs of youth (MBC5, MBC7, MBC14). The need for a continuum of responses rooted more in support than control is a key theme in this data set.

A storyline of reform. While the policy actions in the Manitoba data set supported a storyline of control where concerns raised are met with a black and white governmental response aiming to meet questions and concerns with reassurances of existing legislative supports, in the BC data set, the analysis shows more of a storyline of reform emerging. In general, the BC data set is characterized by a philosophical tone, with media stories presenting different viewpoints on decriminalization, reconciliation, privacy laws, free will, that focus on the "why" and "how" of MHSUD service delivery, rather than simply logistics. For example, discussions of Vancouver City Council's work on decriminalization includes input and criticisms from drug users themselves (MBC4). In addition, discussions about privacy laws and involuntary holds for youth include opposing viewpoints (MBC5). Furthermore, government speakers sharing concern and questions with existing policy frameworks—including pausing bills in the legislature that might ratify involuntary admissions—rather than pat answers about control (MBC6).

Key takeaways. The analysis of the BC media data set points to a policy subsystem struggling through how to position policy responses to MHSUD which are ethical, culturally competent, inclusive and effective. This struggle is situated in a storyline of reform which shows some evidence of self-reflection on the part of policy actors and also reflects a system which admits to not yet having "gotten it right." Legalities regarding where supports ought to begin and end, decisions about what is funded and what is not funded play itself out in the media storyline. However, a key and recurring theme, in discussions of legalities of involuntary holds, of funded services and defunded services, and of advocacy groups highlighting the lack of effectiveness in the current system, is the theme of the need for a robust continuum of supports for MHSUD. The analysis shows a united investment in culturally responsive care that meets the needs of youth where they are, and reflects a system in which preventative programming in schools and early

intervention in community, and a reliance involuntary holds in absence of other treatment options, are not enough to meet the needs of youth.

Provincial Advocate Offices

Both BC and Manitoba have legislation outlining the role of a provincial advocate groups in advocating for youth in general, and MHSUD services for youth in particular. This includes investigations into deaths of youth with a focus on youth who were connected with child-serving systems, reports to provincial governments with recommendations to support youth, and monitoring implementation of the recommendations the office makes to ministerial bodies (MACY, 2023). It is of note that many of these advocate reports deal with MHSUD alongside other important youth issues including outcomes of youth in care, suicide, sexual exploitation and homelessness. In cases where MHSUD is not the primary issue investigated, the documents have still been included for examination and only data collection relevant to MHSUD is included.

For each of the identified documents (as listed in Table 5.3), I collated data to clarify the governmental policy actions represented in the document, the critiques or concerns with existing policy structures, and recommendations made by the Advocate/Representative's offices. In keeping with examination of government-affiliated stakeholder policy documents in sections 5.3.2 and 5.3.3, I examined existing policy structures and critiques as being related to: (a) discourses of intent for MHSUD care; (b) discourses of action; and (c) discourses of coordination. Following a collation of data for both jurisdictions, I analyze the emerging themes.

Manitoba Advocate for Children and Youth (MACY). The analysis for MACY includes the 11 provincial reports published since 2018, which is when the Advocate office

expanded its mandate to include reporting youth fatalities and making legislative recommendations to governmental ministries. Existing policy subsystem values, actions and coalitions represented, critiques of existing values, actions and coalitions and recommendations by document, are presented in Table 5.22.

Table 5.22 Manitoba Advocate for Children and Youth (MACY) Identified Documents for Review[18]

Document *Impetus or Positioning of Report*	**Existing policy subsystem values, actions and coalitions represented** (specific to MHSUD) **(I)- intents (A)=actions (C)=coalitions**	**Critiques of existing policy subsystem actions and coalitions** (specific to MHSUD) **(I) = intents (A)=actions (C)=coalitions**	**Strategies and coalitions recommended** (specific to MHSUD) **(I)- intents (A)=actionsns (C)=coalitions**
Rights Delayed are Rights Denied (2023) *Following lack of perceived progress by provincial government on a youth MHSUS strategy.*	**(A)** Report on advocate past recommendations, report finds full or large amount of compliance with: • Trauma prevention and education initiatives • Establishment of Education SEL learning outcomes • Education promotion of safe and caring schools • Youth-based access point for MHSUD • Inventory of MHSUD treatments, including youth hubs • Focal points outside of Winnipeg **(A)** Limited compliance with: • Reform treatments to include safe spaces for youth • Increase involuntary holds in Drug Stabilization Act • Establish cross-sectoral strategy for MHSUD • Develop youth MHSUD strategy • Long term residential MHSUD treatment for youth • Roadmap with outcomes to transform MHSUD systems • Gap analysis of tiered options for youth • Ensure equitable access of services • Implement the youth recommendations in the Virgo Report • Utilize system navigators to support families	**(A, I)** Most of the recommendations for youth MHSUD have not been implemented, despite the fact that most common interaction by youth and families with MACY is due to "deficiencies in case planning" for MHSUD (2023, p. 32) **(A, I)** Despite past recommendations, "No child-specific mental health and addictions strategy exists" (p. 32) **(A)** Roadmap document put forward by MMHCW lacks "detailed and measurable strategy" and is absent of any specific targets (p. 32).	• Implementation of a "child-specific mental health and addictions strategy" (p. 26) • Full implementation of all reported recommendations from previous advocate reports.
Finding the Way Back: 45 Boys Who Died by Suicide or Homicide (2021a) *Report on oversights in child-serving systems.*		**(I)** Advocate shares documentation of inherent racism and a centering of the white experience in the MHSUD care system in Manitoba. **(I)** Youth in the current service delivery framework are met with inconsistent and disjointed supports.	• Implementation of evidence-based, culturally safe MHSUD supports • Culturally safe engagement initiatives for Indigenous boys • School anti-racism training • Gang strategy for Manitoba • Development of actionable and trackable youth MHSUD strategy
Right to Be Heard: MACY 2021 Listening Tour (2021b)	**(A)** MACY Listening Tour engages with youth via interviews and forums to engage youth about experiences and needs with child-serving systems	**(I)** Youth identify substance use as their top concern, and mental health as their second concern but indicate current MHSUD supports in Manitoba are insufficient and not meeting their needs.	Youth recommendations • Access to free MHSUD supports–elimination of waitlists • 24 hour drop in or home program • Harm reduction strategies

[18] In both the case of Manitoba and British Columbia, the Advocate or Representative has a legislated responsibility to investigate the deaths of youth, and to produce reports for the provincial government based on issues it deems important. Within this mandate, many of these documents speak to MHSUD issues and concerns in youth as part of larger critiques of topics including homelessness, outcomes for youth in care, protection of vulnerable youth. For the purposes of this review, I have only collected and coded data within these documents dealing directly with MHSUD and thus the number of discourses vary based on whether MHSUD was a primary or periphery topic in the report.

Data collection from youth.	**(A)** Youth reported on health, social, educational experiences as legislated by Ministries of Health, Families and Education	**(A)** Waitlists result in youth not getting care when they actually need or want it.	• Long term treatment options • Increase involuntary stabilization • Free recreational activities • Culturally appropriate care • More options in supports provided • More trained professionals • Spiritual supports • Stronger support programs
Kids Can't Keep Waiting (2021c) *Following perceived lack of progress in MACY recommendations.*	**(A)** MACY indicates Ministry of Education has implemented recommendations for MHSUD since past report: (1) Highlight SEL learning outcomes in the curriculum (2) Continue promoting Safe and Caring Schools via the *Planning for Safety and Belonging* document rooted in Comprehensive School Health. **(A, V)** Other recommendations from other sectors not complete	**(C)** In some cases, ministries cite that they are waiting on implementation from other sectors prior to implementing recommendations, rather than co-planning.	• Continue to implement all recommendations from previous reports related to MHSUD • MACY indicates there still needs to be an increase in collaboration and coordination across government with respect to recommendation implementation.
Still Waiting: Phoenix Sinclair (2021d) *Following death of youth in care with MHSUD needs.*	**(C, A)** Due to the inability of the health system to keep up, there is "increased pressure on child welfare agencies to address issues related to mental health, justice matters and poverty" (p. 25).	**(A, C)** Need to employ "systemic enablers of wellbeing" (p. 24) where schools, hospitals, mental health programs work together to be instrumental to healthy families so that CFS is not tasked with addressing health issues in addition to social.	• Call to utilize socio-ecological health approaches and cross-disciplinary support for wellbeing of youth and of families.
Are They Listening (2020a) *Compliance Summary*	**(A)** Manitoba Health has responded to past MACY MHSUD recommendations "by providing a list of various investments made for children and youth" (p. 21), **(I)** Government approach focus on "demonstration mode" or "pilot testing" of possible strategies resulting in program instability and waits (p. 24).	**(A, I)** MHSUD care for youth "woefully inadequate"; systems like "mental health and additions are…allowed to walk away from families" (p. 23). **(A, C)** The province's "ongoing reliance on reviews without concrete plans have continued to result in low compliance assessments" (p. 20); "of concern, many recent announcements are for one-off or short-term investments, and are not linked to a broader action plan or sustained strategy" (p. 22).	• Publish and take immediate action on reviews of child-serving systems • Release an action plan with timelines to address MHSUD
Stop Giving Me a Number and Start Giving Me a Person (2020b) *Collated data on youth barriers to MHSUD care.*	**(I)** Virgo Report identifies significant underfunding of MHSUD provincially, describes MHSUD supports as being in "demonstration mode", **(I)** In addition to MHSUD programming through RHAs, government notes addition of Strongest Families Institute (with a no waitlist policy), Norwest Hub – additional funding, Project 11 supports funded in schools, and Thrival Kits to support SEL programming for youth. **(C)** Children's Hospital is identified point of contact for crisis services.	**(A)** Structure of MHSUD system is not child-focused: waitlists, restrictive criteria, and ironically high vacancy rates require families (and schools) to hold youth together until help is offered. **(A, I, C)** Documented barriers to care: • inconsistent service access and service quality • lack of coordination between providers, sectors, and levels of care • lack of access to culturally appropriate services that meet the needs of youth **(A, C)** Intensive hospital treatment is short term and not paired with robust follow-up supports: • youth who want to avoid system are discharged;	• Conduct a gap analysis of MHSUD supports for youth • Demonstrate equitable access to service • Create a provincial strategy to support youth MHSUD • Train all child-serving systems workers on the effects of trauma • Help families learn where resources are • Create more youth hubs

		• strong pattern of repeated intensive visits due to overdose, suicidality does not trigger aftercare; • intensive hospital visits treated as a stand alone; • youth caught in a cycle of accessing intensive supports, being sent home, and then not receiving outpatient supports that meet needs.	
The Slow Disappearance of Matthew (2020c) *Follwing death of youth with MHSUD needs.*	**(A, C)** At time of writing HSC only point of entry for intensive MHSUD supports. **(A, I)** MH legislates MHSUD care provincially, ME has code of conduct, bullying guidelines, mandate to provide safe and caring schools which plan for safety and belonging. Intensive supports in PY1 well-suited to the types of needs youth had.	**(A, C)** Service provision caught in a cycle of "utilizing the same services in the same way, with the same recommendations, the same outcomes and no sustained improvement" (p. 42). **(C)** Triage process for intensive care results in a new physician each time which is repetitive and puts youth with intensive needs back in the queue over and over. Intensive wraparound supports from PY1 not supported in aftercare models **(A)** Youth absent/unable to attend therapy due to worsening MHSUD symptoms deemed "resistant to treatment" (p. 68) **(A)** Exclusionary school discipline strategies serve to alienate youth further from the school system, exacerbate mental health concerns.	• Improve access for yout MHSUD • Look at Ontario model which uses system navigators assigned to youth with MHSUD to help families navigate the system • Creation of a residential facility for intensive MHSUD • Elimination of suspensions and expulsions except for safety concerns • Improved plan for bullying via planning for safety and belonging • School-based prevention • Positive discipline models with holistic responses • Establishment of a MHSUD strategy for youth in Manitoba
A Place Where it Feels Like Home (2019) *Following death of youth in care.*		**(A)** School disciplinary consequences included suspension and expulsion remove victimized youth from supports, structure and resources. **(A, I)** No MHSUD strategy, particularly for exploited youth with unique needs. **(I, C)** If youth do not fit the offered strategies and resources, there are not alternative options.	• Reduction in the use of suspensions and expulsions • Development of a clear plan and continuum of resources for youth MHSUD provincially • Improvement in consistency in victim's services for youth including MHSUD supports for exploited youth
In Need of Protection – Angel's Story (2018a) *Following death of a youth in care.*		**(A, C)** Manitoba lacks viable treatment options for youth with life-threatening MHSUD. Youth are bounced from initiative to initiative without overarching plans.	• Robust youth addiction strategy with outcomes, strategies and measurable indicators of success • System-wide learning for child-serving sectors on trauma-responsive systems
Documenting the Decline (2018b) *Following death of a youth in care.*	**(A)** In Manitoba, substance use counselling and preventative programming is inconsistent; "43 of 263 schools have in-school AFM services" (p. 45).	**(C, A)** Existing system results in "a collection of missed opportunities" (p. 11) as supports are implemented in a way that is inconsistent and sporadic. **(C)** AFM policies do not include sharing concerning amounts of drug/alcohol use with families; addiction services operated in isolation of MH services and did not share vital information with caregivers.	• Overarching plan for MHSUD supports so that youth don't fall through the cracks • Improved information sharing between sectors to support youth • Restorative disciplinary strategies that build and affirm youth

Themes in discourses of intent. Many of the values that are represented in the MACY reports examined are in the form of policy inaction. In ACF model, if we consider policy actions that *were* taken actions as acting support of particular secondary beliefs, then policy actions that were *not* taken can be seen as reflecting a lack of support for other values. These "policy silences"—places where policymakers have not chosen to take action (Rizvi & Lingard, 2009, p. 14)—are noteworthy in the analysis MACY data set. A key exemplar of this is inaction on a youth specific MHSUD strategy in Manitoba. MACY has declared MHSUD "the most pervasive systemic issue that we continue to see in our work with children" (MACY, 2023, p. 30) and youth identify MHSUD as their top concern in Manitoba (MACY, 2023). Despite this, there are no overtly named strategies for youth in provincial Ministries of Education, CFS, Health, or Mental Health. Related to this, recommendations to increased culturally responsive care have not been met (MACY, 2021). MACY argues that this lack of central consideration of youth experience when establishing MHSUD service frameworks is echoed in the exclusion of youth voices from both the Virgo Report (2018) and the MMHA Pathway document (2021), including the unwillingness of the Virgo Report to access youth-specific data from MACY (2021).

Themes in discourses of action in MACY documents. A key theme in policy actions that are represented and critiqued in the MACY data set emerged when I examined the initiatives that were gauged to be compliant or largely compliant in compliance reports. Without exception, single-sector responses employing sort of one-and-done checklist actions were evident. For example developing training modules, releasing a document, updating a website, and promoting existing policy guidelines were policy actions deemed fully or mostly compliant by MACY. By comparison, recommendations found partly compliant or non-compliant were actions which required cross-sector collaboration directing policy integration or double loop learning involving

multi-step actions and long-term planning. For example, cross-sector processes to respond to MHSUD would benefit from a gap analysis to determine gaps in Multi-tiered Systems of Support. In the MACY documents, consideration of different types of treatment options were all rooted in the recommendation to establish a "concerted and cross-sectoral process to reduce real and perceived jurisdictional boundaries that prevent access" (MACY, 2023, p. 30), but without a clear analysis of where those supports are most needed. This is despite ongoing calls to develop a child-specific framework for tiered MHSUD supports in 2018, 2019, 2020 and 2023 without action in this area. Instead, while the government has taken action on a MHSUD strategy, MACY argues that the *Roadmap* document put forward by MB/MMHCW lacks "detailed and measurable strategy" and is absent of any specific targets (2023, p. 32). Furthermore, it is rooted not in a comprehensive strategy, but an "ongoing reliance on reviews without concrete plans…[resulting] in low compliance assessments" (p. 20). MACY cites the Virgo Report's analysis that the Manitoba government's holding pattern in a "demonstration mode" or "pilot testing" mode (2020a, p. 24) with "announcements… for one-off or short-term investments, and are not linked to a broader action plan or sustained strategy" (MACY, 2020a, p. 22). This results in a lack of willingness to tackle complex, cross-sector ministerial portfolios that are mired in isomorphism. In sum, a strategic plan without measurable targets, outcomes, or indicators in a complex and multilevel governance system reads more like a bureaucratic exercise than an actual strategy aiming for youth support.

Related to the theme of a reliance on check-list policy actions and pilot projects without actionable strategic planning, MACY identified two key policy action themes within the broader MHSUD service system: 1) an absence of a proper continuum of youth MHSUD supports and services in the Manitoba subsystem; and 2) the failure of intensive treatment options to meet the

needs of youth. MACY argues that the existing system results in "a collection of missed opportunities" (MACY, 2018, p. 11) as supports are implemented in a way that is inconsistent and sporadic. As a result of few access points without a full continuum of tiered support options, the result is that youth are caught in a cycle of "utilizing the same services in the same way, with the same recommendations, the same outcomes and no sustained improvement" (MACY, 2020c, p. 42). Youth absent/unable to attend therapy due to worsening MHSUD symptoms deemed "resistant to treatment" (MACY, 2020c, p. 68). This draws an important insight into value positioning as well, as the existing service delivery structure seems to imply that youth ought to be ready for the services that are offered, rather than ensuring that services offered meet the needs of youth. MACY argues that data from youth shows that in the existing system, the lack of "basic availability and barriers to accessing services [has] profound impacts on the lives of youth" (MACY, 2020, p. 19).

For youth with intensive treatment needs, including hospital-based, residential, and long-term care, MACY argues that triage process for intensive care in the current system requires youth to see a new physician each time they are sent to hospital, which is repetitive and puts youth with intensive needs back in the queue over and over (2020c). Furthermore, intensive wraparound supports from in-patient programs are found to be unsupported in aftercare models (MACY, 2020c). MACY argues that Manitoba lacks viable treatment options for youth with life-threatening MHSUD and youth are bounced from initiative to initiative without overarching plans (MACY, 2018). And I note here--though MACY does not--that in the absence of aftercare wraparound plans, schools often take on this work in schools by virtue of their quotidian involvement with youth.

A final theme in policy actions in the MACY data set is the argument that school disciplinary consequences included suspension and expulsion remove victimized youth from supports, structures, and resources. This theme is present in four of the examined documents (MACY, 2021a; 2020c; 2019; 2018b) and is rooted in the treatment of MHSUD as a code of conduct issue within Manitoba Education. MACY argues that "education [has] a lasting opportunity to provide some stability and a safe place to learn" (MACY, 2018b, p. 46), but that youth with MHSUD are often removed from this support by virtue of their substance use.

Themes in discourses of coordination in MACY documents. The analysis identifies how MACY has consistently pointed out limitations for coordination. MACY pointed out how there a "lack of a visible and well-articulated cross-governmental effort to address [MACY] recommendations" (MACY, 2023, p. 28) by virtue of the siloed ministerial model in Manitoba. Due to an identified fractured structure for ministerial action, MACY designates primary ministries responsible for implementing MACY recommendations, which means that MACY is also stuck working within ministerial boundaries. MACY noted that progress on recommendations is often held up as, ministries cite that they are waiting on implementation from other sectors prior to implementing recommendations, rather than co-planning (2021c). MACY argued that the rescinding of the Healthy Child Manitoba Office—a platform for shared ministerial planning for the needs of children and youth—in 2020 was replaced with no alternative for cross sectoral collaboration on common issues such as youth MHSUD (2021c).

A strong theme in the analysis is the lack of coordination between access points, service providers and triage mechanisms; a key consideration in moving MHSUD supports to Shared Health provincially, as noted in the section above. In lieu of a proper framework for MHSUD with a continuum of supports, MACY argued for helping families learn where resources are, and

creating more youth hubs (MACY, 2020). Insofar as a lack of a continuum of supports and of coordination between supports are identified as barriers, it seems that MB/MMHCW, through the *Health System Transformation Plan*, has focused on the second issue as an immediate goal.

Key takeaways: MACY. In the analysis of MACY data set it becomes evident how MACY draws attention to the lack of cohesive plan for youth MHSUD resulting in barriers to care, lack of treatment options that are youth-specific, and lack of coordination between service providers. MACY argues that without a tiered system with the right kinds of supports to serve youth, there is an over-reliance on sectors without waitlists. For example, they argued that with an inability of the current health-based models for MHSUD to keep up, there is an "increased pressure on child welfare agencies to address issues related to mental health, justice matters and poverty" (MACY, 2021d, p. 25). This also places an increased pressure on schools to be serving youth with these same needs.

MACY cited the demonstrated lack of coordination between sectors serving youth, amplified by removal of MB/HCMO, and finds that in lieu of a cohesive plan and framework to support a continuum of responses for youth MHSUD, the province finds itself mired on photo ops and pilot programs without having done the very difficult work of coordinating self-propelled ministerial systems. A shortage of tiered supports, lack of residential and long-term treatment options, and a paucity of frameworks to support coordination between child-serving ministries is resulting in a lack of youth needs being met.

BC Representative for Children and Youth (RCY). The data set for RCY includes ten reports published since 2015. Existing policy subsystem values, actions, and coalitions represented, critiques of existing values, actions, and coalitions and recommendations by document are presented in Table 5.23.

Table 5.23 BC Representative for Children and Youth (RCY) Identified Documents for Review

Document *Impetus or Positioning of Report (value position)*	**Existing policy subsystem intents, actions and coalitions represented** (specific to MHSUD) **(I)=intents** **(A)=actions** **(C)=coalitions**	**Critiques of existing policy subsystem** intents**, actions and coalitions** (specific to MHSUD) **(I)=intents** **(A)=actions** **(C)=coalitions**	**Intents, strategies and coalitions recommended** (specific to MHSUD)
A Parent's Responsibility: Government's Obligation to Improve Mental Health Outcomes for Children in Care (2022) *Following release of 2017 MMHA Roadmap RCY draws attention to fact that while there are youth strategies in the report, youth in care are not well represented.*	**(A)** Representative for Children and Youth Act gives RCY authority to make recommendations via reports it deems necessary. **(A,I)** Report by Select Standing Committee on Children and Youth (SSCCY) (2016) has taken up recommendations from RCY regarding mental health in general and mental health for youth in care in particular to offer specific non-partisan recommendations for government. **(A)** Many of these recommendations stemming from RCY reports and SSCCY have been implemented in governance shifts, including the creation of the MMHA, the 2017 *Roadmap* strategic plan from MMHA. **(A)** MCFD is "currently engaged in a process review of the CFS Act" with a view to "reforming and modernizing this legislation" so that MHSUD needs and supports are overtly cited in the legislation planning for youth in care.	**I, A)** Despite knowledge of a "high prevalence of mental health disorders among children in care" (p. 10) and the over-representation of Indigenous youth in care, MHSUD for youth in care lacks "an organized system of targeted, trauma-informed and evidence-based mental health intervention services" (p. 13). In particular, RCY finds that preventative MHSUD screening and tiered responses for youth in care is vital given their risk. **(C, I)** Culturally responsive care for youth in care is lacking. **(I)** Despite MCFD's role in supporting youth MHSUD supports, the CFS Act itself does not specify mental health as a service mandate for youth in care, which results in social workers trying to work within mandates for health care provision to support MHSUD supports for youth in care.	• CFD to conduct or commission comprehensive research that identifies MHSUD rates in youth in care. • Implement preventative MHSUD screening for all youth in care to determine care plans. • Ensure there is an organized system of tiered, trauma-informed supports for youth in care. • Ensure options for culturally responsive care for youth in care.
Marginalized to Magnified: Youth Homelessness Solutions (2020) *Recommendations from BC youth following an engagement tour by the RCY.*	**(C)** CFD provides youth MHSUD services provision and case management when family issues or housing issues for youth are reported to them as per the CFS Act. MHSUD treatments are provided through MH and legislated through MMHA.	**(I)** Often, value judgement about drug use impede harm reduction supports like safe supply. **(A)** Not enough MHSUD supports preventatively as MHSUD often leads to homelessness. Lack of wraparound, holistic services. **(I, A)** Barriers such as waitlists, costs, eligibility criteria (for example, needing to be "clean" to access mental health supports) impede care.	• Access to a continuum of government funded options to meet youth needs, not adult values
Detained: Rights of Children and Youth Under the Mental Health Act (2021) *Following concerns with involuntary admissions criteria.*	**(A) "**When children and youth require treatment and cannot be treated voluntarily, BC's Mental Health Act allows for involuntary health treatment"(p. 3). **(A)** Admission rates for involuntary holds have been raised by 162% in ten years in BC. There is an over-representation of Indigenous youth.	**(I, A, C)** A lack of continuum of appropriate resources results in over-reliance on 'last-hope' options such as involuntary admissions. **(I, A)** Youth are not aware of their rights and involuntary holds result in a lack of agency and advocacy for self. **(A, C)** Involuntary holds often not paired with appropriate aftercare plans and supports and instead operates as a standalone intensive service that is traumatic for youth. **(I, A)** Hospital holds often do not work to address core issues but offer a "biomedical" approach via diagnosis and treatment via medication.	• Identify why there is such an increase in involuntary admission, share disaggregated data with an independent body and with First Nations. • Ensure a continuum of trauma-informed, culturally competent care for youth MHSUD that has treatment options at identified (six) tiers of needs to reduce likelihood intensive supports are needed.

			• Respond to youth MHSUD via a socio-ecological model of wellness that is youth, family, and culture centered. • Amend legislation to ensure isolation, restraint are only used as a last resort. • Investigate modifications to legislation which allow parents to request involuntary holds.
Caught in the Middle (2019) *RCY Report following the death of a youth in care with jurisdictional disputes between two provinces.*	**(A)** Ministries of social services in both provinces have their own processes for record keeping and management of youth in care, and also their own budgets related to provision of services for youth in care which often do not align. **(A)** MCFD is tasked with the need to "assess the need for residential care and treatment resources… to accommodate children with complex needs " (p. 45).	**(A, I)** Recommendations to stabilize substance use disorders prior to administration of mental health supports are outdated and do not align with evidence base on concurrent service provision. **(A, C)** In the case of youth with profound needs, there is a lack of "robust services and residential treatment options" (p. 53). In the case of the youth in question, there were times that the only services supporting were the school and parole officer.	• Improve coordination of service provision and offering of service provision to ensure that youth with complex, multi-modal and intensive needs have supports available.
Time to Listen: Youth Voices on Substance Use (2018) *Data following interviews, critical injury reports to collate youth perspectives on MHSUD care.*	**(V)** Report is positioned pre-substances strategy through MMHA but post declaration of MHSUD as a public health crisis in BC.	**(I, A)** Safer use options keep youth safe until they are ready for treatment. **(A, I)** Important for "schools being able to work with students who are struggling with substance use rather than suspending them" (p. 2). Punitive policies lead youth to hide their substance use, not seek help. **(I, A)** Youth are often deemed "resistant to service" when in reality the service is not meeting their needs. **(I)** Scare tactics often get used in place of accurate, non-biased information. Youth appreciated mentors with lived experience. **(A)** Early intervention to manage social emotional competency and accessible counselling supports were seen as important preventative programming by youth.	• MMHA commit to youth engagement in a youth MHSUD strategy • MMHA lead development of an accessible single source of MHSUD services for youth in BC • Implementation of a comprehensive continuum of accessible supports with culturally competent care • Implementation of a continuum of harm-reduction strategies for youth • Increased MHSUD supports in schools • Increase in long-term care options
Missing Pieces: Joshua's Story (2017a) *Following death of a youth in care with MHSUD needs.*	**(C)** CFD provides youth MHSUD services provision and case management for youth when concerns are reported to them as per the CFS Act.	**(A)** Intensive supports were not provided to the youth in question, despite very clear intensive needs. **(A, I)** Services that did not meet needs of youth were referenced in a way that indicated youth refused services.	• Implement a continuum of MHSUD services for all youth but youth in care in particular with options for intensive services.
Broken Promises: Alex's Story (2017b) *Following death of a youth in care*	**(C)** CFD provides youth MHSUD services provision and case management for youth when concerns are reported to them as per the CFS Act.	**(A)** Provision of MHSUD services deemed interrupted and disjointed. For youth in care with complex and ongoing needs a cohesive plan for wellbeing and well becoming is missing.	• MCFD to investigate possibilities for permanency and connection for youth in care. • Provision of case management with cohesive and tiered MHSUD

with MHSUD needs.			supports rooted in culturally competent care.
Review of Substance Use Services in BC (2016a)	**(C)** Currently a "multi-jurisdictional environment" of services and supports for MHSUD in BC (p. 12).	**(C)** Not only are there gaps in the system, there is "the absence of an actual system with no single entity responsible for MHSUD" (p. 12). Lack of provincial leadership consistency. **(A)** Documented service gaps included: rural areas, school-based supports, treatment for concurrent disorders, transfer-point consistency, consistency in withdrawal management supports, residential and long-term treatment options, intensive or tier 5 services, formalized aftercare supports, eligibility restrictions, caregiver supports, specific supports for marginalized youth, culturally competent care. **(A, C)** Tiered continuum of service delivery for MHSUD is vital as "no one approach would suit all individuals… different populations have different service needs" (p. 14). This will require "collaboration and coordination of services [and[system planning" (p. 14).	• Creation of a single point of leadership for MHSUD provincially • Five-year strategic plan for youth MHSUD including coordination and cross-sector policies • Anti-stigma campaigns.
Last Resort: One Family's Tragic Story (2016b) *Following death of youth requiring intensive MHSUD supports*.	**(A, C)** While MH controls health-based responses to MHSUD and MCFD controls access to youth mental health supports, the Ministry of Justice has access to secure treatment options, monitored support programs and parole-officers who monitor and support young offenders in the community. In the absence of interventions that meet youth need within health and social services, there is often a willingness to have a young offender involved with justice as a catalyst to accessing more intensive MHSUD supports with fewer barriers.	**(A, C)** Demonstrated lack of early intervention and a proper continuum of supports for MHSUD results in an over-reliance on "last-hope", intensive options such as engagement with the Justice system. **(A, C)** If youth are not mentally able to voluntarily engage in MHSUD community-based supports, there is a lack of other options for families to access aside from involuntary holds and justice involvement. **(A, I)** Lack of culturally responsive care decreases the likelihood that youth will want to engage in voluntary, community-based programming. **(A, C)** Secure care options are vital as a portal to other options and aftercare treatment, not as a standalone.	• "Call of MCFD, Ministry of Education, Ministry of Health to co-locate mental health and substance use services in BC schools to increase the ability of youth to engage with services and to help support early identification and intervention" for MHSUD problems (p. 5). • Fund and maintain a comprehensive system of substance use services that consistently meet the needs of youth and their families. • Fund and maintain culturally responsive services.
Paige's Story (2015) *Following death of an youth with ongoing justice/ CFD involvement but lack of wraparound*.	**(A)** CFD provides case management and MHSUD care for youth in care.	**(A, I)** Storyline of "service resistant" is used for youth with high-needs as a way to "normalize unacceptable outcomes' (p. 40). **(A, I)** Risk protection and provision of services did not match need for highly at-risk and marginalized youth; "normalization of unacceptable outcomes" (p. 51).	• Supports and services must meet needs of marginalized youth rather than inaction that serves to "normalize unacceptable outcomes" (p. 51).

Themes in discourses of intent. In terms of value positions highlighted in the RCY documents, there are recurring themes regarding qualification/disqualification of services, and regarding which values services are intended to reflect. For example, in the RCY data set, the analysis shows how critiques call into question a lack of culturally responsive supports (2016b), supports for marginalized and homeless youth (2020), supports for youth in care (2023), and supports for youth who are actively using drugs (2018). RCY argues that while there has been significant work provincially (between 2019 and 2023 in particular, by *Pathway to Hope* strategic plan document from the BC/MMHA) on youth MHSUD in sectors of BC/MH, BC/MCFD and BC/MECC, that marginalized youth have a long history of not having supports and services to meet their needs. Furthermore, RCY argues a storyline of youth being "service resistant" is often used for youth with high-needs as a way to "normalize unacceptable outcomes' (RCY, 2015, p. 40). That is, youth are often deemed "resistant to service" when in reality services are not meeting their needs (RCY, 2017). RCY cited instances when youth were denied mental health support by virtue of drug use (RCY, 2018), nicotine use (RCY, 2016b), or where treatment options failed to consider harm reduction strategies, such as safe supply reflecting adult values, not youth needs (RCY, 2018). This suggests some ongoing stigma with MHSUD supports despite provincial direction and cross-sector service direction for MHSUD.

Themes is discourses of action in RCY documents. The analysis demonstrates that a key difference in the RCY data set compared to MACY's is its advocacy role for particular groups of marginalized youth MHSUD supports. It is important to note that RCY is advocating for youth MHSUD in a province which is four years into a cross-sector strategic plan for youth MHSUD. In 2016, RCY estimated that there were 68,000 youth in need of substance use services with 24 publicly funded treatment beds in BC. Much of the work of RCY in their reports has focussed

around the need for a robust continuum of MHSUD supports for youth centered in a socio-ecological model of wellness that is youth, family, and culture centered, rather than biomedical responses of diagnosis and standardized treatment (RCY, 2021). In 2016, RCY argued that not only are there gaps in the MHSUD system, there was "the absence of an actual system with no single entity responsible for MHSUD" (RCY, 2016, p. 12). Since then, improved system focuses through the BC/MMHA and its 2019 strategic plan has focused cross-sector partners (Health, Education, MCFD) on shared outcomes to support youth MHSUD responses. This seems to align with RCY's recommendation that a tiered continuum of service delivery for MHSUD is vital as "no one approach would suit all individuals… different populations have different service needs" (RCY, 2016b, p. 14), and that collaboration and coordination of services and system planning is vital for an outcome-rich strategy.

However, even with this improved focus and coordination on a cross-sector MHSUD plan, RCY argues that a demonstrated lack of early intervention and a proper continuum of supports for MHSUD results in an over-reliance on "last-hope" or intensive options. These "last-hope" options, including involuntary admissions (RCY, 2021) and engagement with the Justice system (RCY, 2016) are over utilized resulting from a lack of a proper continuum of suppots. RCY argues that if youth are not mentally able to voluntarily engage in MHSUD community-based supports, there is a lack of other options for families to access aside these intensive options which remove agency from youth (2021). Compounding this, a lack of culturally responsive care decreases the likelihood that youth will want to engage in voluntary, community-based programming (RCY, 2018, 2020). In 2021, RCY argued that secure care options are vital as a portal to other options and aftercare treatment, not as a standalone activity. In 2018, a youth forum highlighted that early intervention programs meant to manage social emotional

competency and accessible counselling supports were seen as important preventative programming by youth, showing identified need at all levels of a continuum of response. RCY is a strong proponent of a multi-modal, tiered system of MHSUD supports (RCY, 2019) to ensure "every door should be the right door" (RCY, 2016, p. 14) and uses data to show that the existing systems is not meeting the needs of all youth, especially not marginalized youth (RCY, 2022).

There are also some noteworthy themes of action in relation to schools in the RCY data set. Similar to the MACY data sample, the RCY data showed that the importance of policy actions which allow "schools being able to work with students who are struggling with substance use rather than suspending them" (RCY, 2018, p. 2). Punitive policies lead youth to hide their substance use, not seek help, and "students who feel connected to their school are less likely to experience subsequent mental health and substance use issues" (RCY, 2018, p. 133). RCY noted that schools play a pivotal role in service provision for youth with MHSUD by virtue of their daily position as case-managers for youth (RCY, 2018). They document instances in which CFD was not able to fulfil responsibilities of referral to specialized programs and supports, and in which the school stepped in to support with this MHSUD support and triage (RCY, 2021). School support programs were deemed an integral support for youth insofar as when other services disconnected, school systems acted to send referrals or garner support (RCY, 2016). However, RCY also documents times when schools' opportunities to act as early-identifiers and early-interveners in youth MHSUD were missed or passed without proper coordination with other sectors (RCY, 2016). That is, the RCY presents the potential of schools to act as MHSUD supports with inclusive and supportive strategies when they have the resources to do so.

Themes in discourses of coordination. The analysis of RCY documents brings to light themes that relate to limited policy integration and coordination at the ministerial level, and

service-coordination realities at the local level. Provincially, RCY identifies the lack of coordination between the two BC/MCFD mandates—providing youth mental health services and case managing youth requiring care. RCY documents highlight that the CFS Act does not specify mental health as a service mandate for youth in care, which results in social workers trying to work within mandates for health care provision to support MHSUD supports for youth in care.

In 2016 RCY highlighted "gaps in available and appropriate support services, issues with communications between service providers and families" within a "substance use system that in spite of good intentions and dedicated front line employees was insufficient to meet the needs of families and youth" (RCY, 2016, p. 36). Though work was taken on after 2016 to improve service coordination and service access, RCY still later found that service provision for youth with complex needs was not meeting the youth that required it, and that "addictions and mental health are huge pathways into homelessness" (RCY, 2020, p. 9). That is, in the case of youth with MHSUD, there is a lack of "robust services and residential treatment options" (2019, p. 53) and RCY found that often, despite significant MHSUD needs, only single-sector responses were in place (for example, only education, or only justice working with youth and family).

Key takeaways. In the BC/RCY data set the analysis highlights a focus not on service provision for youth MHSUD in general, but on service provision specifically for marginalized youth. The availability of services for some, but not for others, raises questions about the values inherent in the system which makes decisions on who is eligible or ineligible for dedicated supports. For example, identification of the "limited placement options for children and youth with complex care needs under CFS service delivery" (RCY, 2018, p. 44) and the lack of culturally competent care are prevalent comments made in the documentation.

Furthermore, the RCY data set shows that while there has been considerable work in the BC subsystem to establish a continuum of tiered resources to meet youth needs, rather than bureaucratic needs, youth indicate that supports offered are not always the supports they require, citing lack of availability of care, responses that require substance use treatment prior to accessing mental health treatment, and a lack of harm reduction resources. Furthermore, there is still an over-reliance on intensive, top-tier, "last hope" responses including justice involvement, involuntary holds and voluntary care agreements due to support strategies that meet youth needs. Finally, this analysis shows that schools in the MHSUD subsystem have a history of enacting fractured emphasis on youth with MHSUD. That is, while schools are documented as being an integral support to youth with MHSUD, there is also substantial data showing the power they have to further marginalize youth who require additional supports.

Summary: Non-Governmental Stakeholders

In this section, policy documents from MHCC, media reports from Manitoba and BC, and documents from MACY and RCY were reviewed and analysed. Data was collated to identify responses to the intents, actions, and coalitions in governmental policy actions. Insofar as the existing system has resulted in a "collection of missed opportunities" (MACY, 2018, p. 11), highlighting not only the policy intents, actions, and coalitions themselves, but also the impact and critiques of these actions is important in mapping out where we are now and where policy reform ought to take us in the future. In the next chapter, I begin to summarize the key findings emerging from the analysis of governmental and non-governmental stakeholders and answer the research questions.

Chapter 6: Findings and Answering the Research Questions

This thesis takes on a primary research question: How can policy coordination be utilized to improve multi-sector support for youth with MHSUDs in Manitoban schools? In this chapter, I present the findings by answering each of the sub-questions identified in support of the primary research question:

a) What policy stakeholders and corresponding documents currently guide responses to youth MHSUD in Manitoba and British Columbia in general, and school-based responses in particular?

b) What are the interests, beliefs, policy actions, and coordination mechanisms that are implicit and explicit in these documents?

c) What are the documented impacts of the current policy landscape for youth in both jurisdictions?

d) How do the documented interests, beliefs, policy actions and coordination mechanisms compare between sectors, jurisdictions and levels of government?

e) What can we learn from these comparisons? What recommendations for policy coordination can be made to support MHSUD supports in schools?

I then conclude with what this analysis has shown in terms of the primary research question.

Research Question 1: Policy stakeholders and corresponding documents currently guiding responses to youth MHSUD in Manitoba and British Columbia in general, and school-based responses in particular

In total, I analyzed 165 policy documents from 37 policy actors related to policy responses to MHSUD. In this section, I use the data analyzed in Chapter 5 to summarize the

range of policy actors guiding MHSUD policy responses, examine the potential influence of policy actors by virtue of their own positioning and the policy documents they wield. I, then, further highlight the role of sectored policy actors and trans- or cross- sector policy actors in the Canadian MHSUD policy landscape. This helps us to understand which policies guide school-based responses and how coordination mechanisms support or inhibit policy goals.

Policy Actors and Their Cross-Level Mandates

Policy actors examined in the policy subsystems ofMHSUD across levels included: ministerial sector-specific actors (working in health, mental health, education and social services). At the federal level, official offices (CPHO, CCSA, PHAC) were shown to act in parallel with Health Canada. At the provincial level there were fewer official offices outside of ministerial structures, but Advocates' offices media were seen to be highly influential at this level. At the regional level, sectored actors were seen to fall in line under established ministries to enact the work materially stemming out of provincial symbolic policy documents. In the examined MHSUD policy subsystems, I categorized policy documents by specific roles that the documents were meant to fulfil, including legislative documents, service provision documents, and documents fulfilling an advocacy role. This is in keeping with Dobuzinskis et al.'s (2005) argument that policy actors take on decision-making, knowledge generation and advocacy roles, and Rizvi and Lingard's (2009) understanding of material and symbolic policy actions. The data showed that legislative, service provisional, and advocacy-based roles were not mutually exclusive and may overlap. That is, often policy actors were shown to take on different roles related to different policy actions. For example, some actors took on legislative roles in parallel with a service provision mandate.

As Table 5.3 shows, there are some trends in the ways leveled policy actors influence the policy subsystem of MHSUD. At the federal level, despite Health Canada (HC) taking on a key legislative role as a federal funder for MHSUD in terms of biomedical responses, the highest concentration of advocacy-based stakeholders and policy documents were identified at the federal level. Provincial governments employed a primarily legislative role and regional actors were seen to take on the most service provision work. As discussed in Chapter 4, NGOs carry out advocacy work at each level of government, with federal NGOs acting as co-advocates at the federal level, as partners in service frameworks at the provincial level, and as delegated service providers, often via funding arrangements, at the regional level. The roles of Manitoba Advocate for Children and Youth (MACY) and the Representative for Children and Youth (RCY) provincially position advocate offices to report on regional and individual considerations of policy impacts, and then bring that data to stakeholders at the provincial level. Finally, the media data set showed a tendency for advocacy through media stories to represent individual and local voices and investigation into the provincial and federal positioning of the individual stories.

In looking at systemic change and policy learning, the data showed that national-level, top-down directives which were tied to HC (or other federal office) transfer conditions prompted lower levels of governance to align with transfer payment conditions. For example, pilot projects from PSC continue to run in all provinces by virtue of the injections of funding they represent. Similarly, HC's transfer funding is established with consultation from provincial ministries of health to ensure compliance with funding transfers (HC, 2016a) which included federal discourses of harm reduction and MHSUD service accessibility. Thus, funding serves as a key mechanism for policy change as it is largely interest-driven and serves mandate changes to secondary beliefs (policy responses). Other federal level advocacy initiatives were associated

more with voluntary and inconsistent conformity. For example, calls to embed MTSS for MHSUD in schools from the CPHO have not been shown to be universally implemented in provinces, but rather seen as a voluntary measure for schools to consider.

The data set also showed that provinces hold the bulk of the power to shift existing legislative models for MHSUD by virtue of their legislative powers for health, education, and social services. Thus, tangible efforts for coordinated legislation and subsequent service provision models are best focused in provincial policy. Regional bodies enact directives of provincial legislation, but also have the ability to make local level partnerships to enact change. By virtue of their local positioning, these actions tend to be isolated, grassroots-level changes, and not integrated policy coordination initiatives. **In the Canadian context, then, system reform for MHSUD requires momentum at the provincial level in order to move large-scale policy change forward. However, policy reform at the federal level (which currently operates through inconsistent funding) could help facilitate coordination at the provincial level.**

Policy Actors and Their Cross-Sectorial Mandates

In Canada's federalist system, the analysis of the data set showed that the majority of governmental actors are sectored, making cross-sectorial approaches to common policy issues uncommon and complicated. At the federal level, the bulk of identified MHSUD policy actors were from the health care sector, taking on legislative (HC) or advocacy-based (CCSA, CPHO, JCSH) roles. An exception was Public Safety Canada (PSC) who took on justice and social sector functions as a public safety provider. Indigenous Services Canada (ISC) was shown to take on primarily service-provision roles in the policy subsystem of MHSUD and the Assembly of First Nations (BC/AFN) took on advocacy-based work. At the provincial and regional levels,

the ministerial system was shown to be strongly entrenched where ministries of health (and mental health), education, and social services direct ministerial responses and regional service provision with inconsistency in cross-sector mandates nationally. Regional bodies (including school divisions, health authorities, and child and family service authorities) were shown to follow direction via legislation, mandates, and other guidelines from various provincial ministries.

However, in this dense sectored system, there were some key policy actors (for example, the Canadian Drugs and Substances Strategy, JCSH, BC/SSCCY, and [the now-defunct] Healthy Child Manitoba) who were positioned in cross-sector capacities with a mandate to specifically prompt coordination. In each of these cases, two or more stakeholders combined their resources to create a new policy actor in order to respond to youth MHSUD. The creation of these cross-sector organizational actors was seen to be different than coordination mechanisms between existing policy actors, which are explored later in this chapter. Rather, in this case, these actors were seen to take on Dunst and Bruder's (2006) understanding of service coordinator roles which rise up to coordinate existing service models. Although Dunst and Bruder (2006) are speaking to roles that actors take on at the local level to coordinate existing frameworks, this model also applies to the legislative or ministerial level in which coordinating actors work to force coordination between isomorphic, yet isolated ministries. In Dunst and Bruder's (2006) view, coordination-focused actors take this work on in one of three ways: 1) by creation of an independent body external to existing ministerial actors (in a dedicated and independent model); 2) through participation of coordinated ministries in developing a model for coordination (in a dedicated but not independent model); and 3) through work by service providers to blend policy with another stakeholder group (blended model). For the stakeholders examined in this study, the

following cross-sector stakeholders took on coordinating roles for MHSUD by combining the forces of two or more sectored actors:

a) The Joint Consortium for School Health (JCSH) —which utilizes a blended model where ministerial actors work independently of each other, but with an eye for synergy;
b) The Canadian Drugs and Substances Strategy—which uses a dedicated but dependent model, where Health Canada takes the lead on a cross-sector strategy, while also being a ministerial actor within the broader strategy;
c) Select Standing Committee on Children and Youth (SSCCY)—which uses a dedicated but dependent model, in which representative ministerial actors work together with the aim of enacting coordinated responses to a common issue; and
d) The now-defunct Healthy Child Manitoba Office (HCMO)—which was enacted as a dedicated but dependent model, in which representatives from child-serving ministries collaborated to prompt cross-sector actions in the best interests of youth.

The role of each of these actors is noteworthy as they have taken on a coordination role in the existing ministerial constellation with a unique mandate. Federally, the JCSH works with provincial ministries of education to facilitate policy learning regarding mental health and other facets of comprehensive school health. JCSH is a non-legislative body and does not direct or engage individual mandates. As discussed earlier, this policy actor thus contributes to policy actions unique to individual provincial contexts, as ministers of education choose to enact recommendations in isolation from each other. At the provincial level, BC/SSCCY is a cross-sector, non-partisan office of MLAs which receives formal recommendations from the RCY and then develops independent reports with their own recommendations to the legislature. While Manitoba does have a cross-sector committee to respond to MACY recommendations as well

(MACY Recommendations Action Planning [RAP] Committee) it does not work as a coordinating body, but rather a response pathway for MACY reports. Tasked with the role to oversee Manitoba's public sector response to MACY recommendations (Government of Manitoba, 2019), it relays policy responses on MACY recommendations where responses are organized by ministry responsible as a means of documenting action and maintaining accountability. While the BC model responds via reciprocal interaction, data gathering, and mandate-provision, the Manitoban model serves as more of a checklist of MACY recommendations that are complete and incomplete.

The HCMO, which was repealed in 2020, did have a history of taking on cross-sector initiatives involving youth (Manitoba Laws, 2020). Initiatives including parenting supports and early childhood along with cross-sector strategic plans for youth (HCMO, 2017). Since the dissolution of this cross-sector initiative, the government has moved to a task-force model in which emerging areas of concern are planned for in short-term, outcome-oriented task forces. For example, the Attendance Task Force (Government of Manitoba 2023a) and the Poverty and Education Task Force (Government of Manitoba 2023b) have taken on short-term advisory roles in an attempt to develop cross-sector recommendations from ad-hoc multi-level committee on common issues. These reports, outside the scope of this literature review, work to understand key themes of a common issue, to represent the existing provincial leadership, and then to present recommendations on the common issue (Government of Manitoba, 2023c). However, insofar as the task forces do not have legislative or managerial reach, they serve as additional advocacy bodies in the system framework, rather than coordinators. Furthermore, given that task force groups are made of new membership for separately defined issues, they ostensibly provide

expertise on the common issue at hand, but may lack systemic knowledge of the broad scope of child serving systems in general.

In comparison to Manitoba, BC/MMHA, though an independent ministry itself, was seen to take on a dedicated and independent role in coordinating other ministerial actors (for example, health, education, and social services). It acts as a quasi-cross-sector actor insofar as its most recent strategic plan orchestrates and sets measurable outcomes for ministerial actors. I do not include MB/MMHCW as a cross-sector policy actor in this same vein, since, as demonstrated in the data above, the MB/MMHCW has produced a strategy document outlining goals and hope for collaborative relationships, but this framework does not orchestrate, set strategies, or have measurable outcomes to direct material policy actions in child-serving ministries as we see in the BC/MMHA strategic plan document. **In sum, a key finding is that there is a dearth of trans-sector policy actors nationally (and a complete absence of any in Manitoba) that are positioned in ways to coordinate or manage the interdependencies of cross-sectorial ministerial realities of MHSUD responses.** Given the evidence-base supporting the need for high level policy integration to support policy coordination at the grassroots level (Hogle & Nordbeck, 2012) and the evidence base showing that coordinating actors improve coordination between sectors (Dunst & Bruder, 2006), the lack of such coordination mechanisms serves as a barrier to effective cross-sector policy coordination.

Implications for School-based Responses

In terms of the implications of the policy actors guiding MHSUD responses in schools, the data set shows schools as sites of manifestation for multiple policy pathways. Schools are primarily responsible to follow policy directives from provincial legislation and divisional/district policy. However, other policy actors also influence how schools respond to

student MHSUD. As was shown in the case-example of Hannah, in terms of horizontal responses, schools are sites in which social and health care actors have some jurisdiction by virtue of their mandates to support youth. Thus, these sectoral mandates seep into school-based positionality and school-based MHSUD responses.

Non-ministerial actors in the federalist system also influence school-based reponses. In terms of Indigenous governance, schools have recently become sites for Jordan's Principle funding allocations, and for coordination of those allocations to other sectors (WSD, 2022). At the same time, federal grants (for example, Manitoba's Health Child Grant, funded by the JCSH) require schools and school divisions to meet specific outcomes in order to be eligible for funds while federal offices such as CPHOC and the CCSA make directives to schools that skip provincial legislation, without ties to any funding. Schools are also in the position of responding to media and advocate reports which critique school actions related to MHSUD as a part of their mandate to support all students. That is, the positionality of schools with regards to MHSUD includes a responsibility to implemement mandated policy and legislation, a pressure to implement federal recommendations, and increasing complexity in sourcing out and supporting funding pathways for student care from multiple (often federal) funders. **However, this multiplicitous positioning is framed within this system with very limited coordinating actors, which leaves a responsibility for policy implementation, compliance with best-practice recommendations and navigation of funders to school personnel.**

In response to the research question, "what policy stakeholders and corresponding documents currently guide responses to youth MHSUD in Manitoba and British Columbia in general, and school-based responses in particular?", the data shows a lack of coordination vertically and horizontally. A lack of coordinating actors is seen particularly in Manitoban

schools. Thinking back to the vignette of Hannah at the beginning of this dissertation, we can see that school staff took on coordinating roles within a system that lacked coordination and coordination mechanisms. Despite a significant number of policy actors and policy directives to support youth MHSUD, data shows that coordination between these actors is lacking.

Research Question 2: Interests, Beliefs, Policy Actions, and Coordination Mechanisms Implicit and Explicit in the Documents

Comprehensive analysis of policy intents, actions, and coordination mechanisms have been presented in Chapter 5. In this section, I review and present key themes from this large data set, regarding the interests and beliefs, policy actions, and coordination mechanisms that were demonstrated across the data set. I focus on comparisons between jurisdictions (Manitoba and British Columbia), levels of government (for example, federal, provincial, and regional) and sectors of government (for example, health, education, and social services) in a later section.

Interests and Beliefs Represented: Shifting Discourses of Intent Over Time

Policy analysis of the discourses of intent in the examined documents across the data set demonstrated a shift in policy intent and underlying beliefs in the last decade. Some of the key changes in value positioning seem to have emerged following a shift in federal interest in framing MHSUD as a safety problem—where the national drugs strategy was part of Justice Canada mandate (Justice Canada, 2009)—to treatment of MHSUD as a health care problem, legislated through Health Canada (HC, 2016a). In the last 10 years, a more recent shift in policy intent has been in the treatment of MHSUD as a socio-ecological health issue with footing across ministerial sectors including health, social services, justice, and education (HC, 2019). In

Chapter 5, I presented data that demonstrated that more recent provincial MHSUD responses were rooted in iterations of socio-ecological health championed by federal advocacy work (for example, CPHOC, 2018; PHAC, 2021; CCSA, 2018). In particular, recent (symbolic) strategic planning documents by provincial and regional stakeholders (MMHCW, 2022; MMHA, 2018; MACY, 2022; and RCY, 2022) have utilized discourses of intent that demonstrate an interest in responding to MHSUD with shared involvement from health, social services, and education. However, despite these shifting value positions across levels, past value positions were seen to be lingering and, thus, were shown to, at times, be hindering full movement towards a common discourse of intent or a common discourse regarding MHSUD.

Notably, in the examined data set, discourses of MHSUD as a socio-ecological issue were the most likely to employ discourses of financial cost than any other primary discourse (as shown in Virgo Report [2018], HC [2018], BC/MMHA [2019], BC/ME [2020], CCSA [2020], CPHOC [2018]). In these cases, issues of harms were bolstered by discussions of financial implications, suggesting that narratives of wellness are still not enough to counter-act the stigma associated with MHSUD. Therefore, although there have been movements away from past understanding of MHSUD as a criminal activity, biases still prevail and continue to require policy makers to prove financial feasibility of supports. That is, socio-ecological understandings of MHSUD and socio-ecological discourses of intent still require a policy interest of human capital development (Schultz & Viczko, 2016) to legitimize this policy interest.

Furthermore, despite shifts at all levels towards consideration of socio-ecological understandings of MHSUD with cross-sector mandates, there remain policy stakeholders and intents that serve as relics of competing value systems, including discourses of intent rooted in beliefs of MHSUD as a safety issue (represented by PSC, MB/ME, BC/MECC), a biomedical

health issue (represented by HC, CPHO, MB/MHHLS), a disciplinary issue (represented by MB/ME, BC/MECC) and an Indigenous issue (represented by ISC) among others. Notably, in all stakeholder groups, iterations of MHSUD as a socio-ecological health issue were most enacted in symbolic policy actions in the forms of advocacy work and goal-setting documents. Material policy actions were more often aligned with sectoral values. This was evident in provision of medical services, social services, and educational services from respective ministries. In the BC data set, BC/MMHA seems to have had more success orchestrating common value positions across sectoral actors. This is in part due to the amount of cross-sectoral collaborative work via cross-sectoral actors that preceded the strategic planning document (for example, SSCCY, 2016; RCY. 2010; BC/MH & MCFD, 2010). This data demonstrates the ways in which ministries tend to revert to path dependence and frame values as linked to individual mandates within the large-scale work in the subsystem of MHSUD. Thus, moves out of this path dependence and out of traditional siloed ministerial models will require purposeful and ongoing work.

Furthermore, despite moves to consider MHSUD a cross sector and socio-ecological issue, there remains concurrent work from all stakeholder groups to frame MHSUD as a biomedical issue. Arguably, this is the case for two main reasons: (1) despite significant multilevel work beginning in the 2010s to frame MHSUD as a health issue, mental health still does not have parity in funding or consideration with physical health (MHCC, 2022); and (2) identification of MHSUD as a health care issue allows it to be quickly tied to existing health funding (MHCC, 2018). The MHCC's work over the last five years has been heavily focused around ensuring a level of parity for mental health alongside physical health in terms of funding arrangements federally and provincially (2022). At the provincial and regional levels, the move away from MHSUD as a justice issue overarchingly resulted in service provision being managed

by ministries of health provincially and health care authorities regionally via identification of MHSUD as a health issue (BC/MH, 2023; MB/MHHLS, 2023). This is not to say that MHSUD care does not belong in health care, but rather that it belongs in health care alongside other sectoral ownership. Further, the work done in the mid 2010s to frame MHSUD as a biomedical health issue rather than a criminal issue or a safety issue continues today in shifting discourses of MHSUD away from blame-based ones. This broad societal interest in treating MHSUD as a biomedical issue was heavily driven by medical research working to discredit a binaried and moralistic understanding borne out of a war on drugs in which addiction was seen as a moral failure rather than linked to medical understandngs of genetics and brain science (Heather, 2016). However, insofar as biomedical health issues became entrenched in medical service provision, including funding transfers federally and provincially, discourses of biomedical health care and policy intents rooted in health ministries are difficult to shift specifically because of the existing tie to medical funding. **Thus, a key finding is that policy documents intending to advance understanding of MHSUD as a socio-ecological health issue with focuses on cross-sector and harm reduction mandates are both mired in competing discourses about MHSUD and also fighting with stigma around MHSUD. Discourses of wellness alone are not impactful enough to push policy mandates forward toward prioritizing socio-ecological wellbeing and tend to be bolstered by financial arguments.**

Policy interests and beliefs about MHSUD: Relation to schools. Looking specifically at the policy interests and beliefs about MHSUD in education, the data set showed that the safe schools push of the early 2000s remains a strong narrative in both examined provinces. In Manitoban schools there is still much focus on a primary policy interest being the provision of safe learning environments (Colorado & Janzen, 2020). With that backdrop, the conflation of

discourses of youth substance use with discourses of school safety have been tightly woven (Farrugia, 2014). This is evident in the Manitoba data sets where MHSUD is primarily dealt with in Code of Conduct (MB/ME, 2018). In BC, there is more demonstratable progress with treatment of MHSUD as an issue of prevention (VSB, 2023) and of harms (MBC9), but where the ties to disciplinary responses are still strong. This is evident by an RCY report which recommends "schools being able to work with students who are struggling with substance us instead of suspending them" (RCY, 2018, p. 2). These provincial examples take place within a context in which federal stakeholders are pleading with schools to take on universal primary prevention work to act as a disrupter of stigma in MHSUD (PHAC 2021a, b; 2019a, b, c, d). This also occurs in a context in which both non-government stakeholders such as MACY and RCY have lamented the school's role in alienating youth through disciplinary responses to MHSUD, rather than through offering a continuum of supports. Notably, except for its mention in federal documentation from Public Safety Canada, education is the only child-serving system examined which utilizes discourses where MHSUD is framed as a threat to safety. **A key finding is that despite pushes to employ socio-ecological health supports for MHSUD, there remains an over-reliance on safety-based discourses in school policies with consequent disciplinary action mandate.**

Policy Actions in Support of Policy Intents, Interests, and Beliefs

Wedel et al. (2005) argued that instead of asking what is in policy, we ought to be asking what people do in the name of policy. Given shifts in purported values across all stakeholder groups towards socio-ecological responses to MHSUD, investigating how policy actions are enacted is important. In this section, I review some of the themes that persist *across sectors,*

jurisdictions and levels[19]. A key theme is the embracing (via symbolic policy declarations) the investment in cross-sector approaches to MHSUD, which consider socio-ecological health and harm reduction strategies. A key material policy action in support of understandings of socio-ecological health has been the creation of new ministries of MB/MMHCW (2021) and BC/MMHA (2018) in Manitoba and BC respectively. In advance of the formation of these new ministries, and also in the wake of their evolution within their own contexts, a number of policy documents focusing on re-framing responses to MHSUD have been produced. At federal, provincial and regional levels, this has included the development of a plethora of research, advocacy, and mapping of policy actions rooted in multi-tiered systems of support—sometimes called tiered systems or continuums of support—in responding to MHSUD (AFN, 2011; CCSA, 2017; FNHA, 2021; MACY, 2023; BC/MMHA, 2018; MMHCW, 2022; RCY, 2021; SSCCY, 2016; VCHA, 2023; Virgo, 2018).

Federal symbolic policy actions for youth MHSUD include directives and policy papers outlining the importance of tiered support models. For example, the AFN and the CCSA call for a continuum of care including universal prevention, early identification, brief intervention programs with aftercare, secondary risk assessment, active treatment, and specialized treatment (AFN, 2011; CCSA, 2017). Similarly, HC's policy paper, *Strengthening Approaches to Substance Use* (2019) calls for preventative education and training, and tiered treatment options, including community-based support programs, residential programs, and supports for transition to long term recovery with embedded cross-sectoral collaboration including medical, social, vocational, and educational supports. Though federal policy papers advocating for primary prevention programming in schools are legion (for example, PHAC, 2021a, 2021b, 2019a,

[19] Some of the key considerations in terms of policy actions are best explored by comparing the examined jurisdictions, which I examine in section 6.4

2019b, 2019c; CPHO, 2018; JCSH, 2023), material policy actions at the federal level are more common at targeted and intensive levels. This is evident in funding of provincial treatment initiatives (HC, 2022) and through PSC pilot programs for youth with intensive needs. However, pilot programs for a community-based primary interventions (PHAC, 2021) and universal supports initiated federally through anti-stigma campaigns (HC, 2019) are also noted. That is, there is federal call and direction for embracing tiered approaches to MHSUD including a continuum of supports, and there is evidence at the federal level of universal, targeted, and intensive supports and responses. Insofar as the federal government sets direction but does not legislate health, social services, and education, the symbolic policy actions may be considered of higher importance than the piecemeal pilot programs that go along with them. **That is, while there is federal direction in the form of funding to provincial governments and recommendations to local level actors, lacking is a comprehensive and necessary vision for a cross-Canadian approaches or symbolic coordination through a cross-national Canadian strategy.**

Though different provincial models are used to explore policy action frameworks rooted in continuums of care, the core principals align. In Manitoba, the Virgo Report (2018) stated that the goal of a review and update of MHSUD supports in Manitoba is "an approach which aims to address the needs of the whole community across a full spectrum of severity and complexity…[where] support services are aligned with each tier" (2018, p. xi). The Virgo Report proposed a provincial system that employs five tiers with primary prevention as a tier one response, followed by early intervention and self-management; moderate MHSUD supports including case management, assessment and treatment; intensive and specialized community-based supports; and highly centralized hospital-based supports (p. xii).

In BC, SSCCY (2018) noted the "importance of integrated and coordinated service delivery" (p. 12) and argued that a "multi-disciplinary approach is required [and] services should be provided by the right practitioner at the right intensity at the right time" (p. 13). This support of a continuum-model for MHSUD service provision is supported by school-based exemplars of integrated and cross-sector service pathways. SSCCY positions its 2018 report as a response to RCY's (2016) advocacy for MHSUD youth programming. In keeping with RCY's recommendation, SSCCY also presents MHSUD as requiring a continuum of supports from least to most intensive. RCY's continuum is drawn from the National Treatment Strategy Working Group (2008) tiered support model, which adopts the same five-tier system as is present in the Virgo Report recommendation for a continuum of tiered responses. The RCY and SSCCY documents, it should be noted, are positioned for youth only, as per the organizations' mandates, whereas the Virgo Report is positioned for all Manitobans. RCY advocates for movement away from a one-size-fits-all model where "every door is the right door" (2016, p. 20) and where in keeping with recommendations from HC, least intrusive options are supported first (HC, 2002).

Insofar as the SSCCY report (2018) can be seen as a precursor to the development of the BC/MMHA *Pathway to Hope* document, and the Virgo Report is a precursor to the development of the MB/MMHCW *Pathway to Community Wellness* document, it is important to note how the positioning of each of these seminal policy documents—indeed, policy actions in and of themselves—have positioned policy actions moving forward. While both Virgo (2018) and SSCCY (2016) include documented support and development of paradigms of Multi-tiered Systems of Support (MTSS), the Virgo model is heavily weighed to the health-care system, whereas the SSCCY report is multi-sector in nature and indeed positions much of its advocacy around the work of schools. This is arguably in large part due to the positionality of each actor—

with the Virgo consultancy firm being subcontracted to audit a floundering health care system focused on improving health care systems for MHSUD, and with the SSCCY being made of MLAs from across partisan and ministerial representation focused on improving outcomes for youth. That is, though there are similarities in the types of policy actions represented, and a shared spoken commitment to tiered systems of support across the country, the ways in which the secondary policy actions have been developed are different. **In sum, a key finding related to policy actions is that symbolic declarations in support of a multi-tiered continuum of support for MHSUD are common across jurisdictions and individual sectors but are inconsistently supported by material policy actions employed to support those symbolic policy interests.**

Coordination Mechanisms in the Data Set: Promising Practices

Insofar as the goal of this project is to consider the ways in which policy coordination models can meet the needs of youth in schools, it is worth considering the types of existing models (Peters, 2019) which allow policies to work together. Service coordination models in which funding models vertically employ subsidiary actors in support of a mandate are common in the federalist system (Wiekorowicz, 2001). However, if we are looking at policy integration models where adjustments cause horizontal policy actors to "pursue different policies than they would have chosen had policymaking been unilateral" (Webb, 1995, p. 11), then the focus is shifted to horizontal coordination-based relationships. Insofar as policy integration takes place at higher levels of government to ensure policy is aligned at the service provision level to increase access and reduce redundancies (Hogl & Nordbeck, 2012), horizontal coordination relationships

which also successfully catalyze vertical coordination with lower-level policy actors is key to systemic change (Bakvis & Julliet, 2004).

As discussed in the methodology, policy integration requires comprehensiveness—including the presence of all policy actors in planning; aggregation—fidelity of implementation drawn from systemic knowledge of multi-level implications in the policy landscape; and consistency—with different sectors in accord with both the policy and financial plans (Hogl & Nordbeck, 2012). After reviewing the data from all stakeholder groups, key examples of *coordinated relationships* emerged in which indicators of aggregation, comprehensiveness, and consistency were all met. I examine them here as promising practices across the data set[20]. In examining these promising practices for policy integration and policy coordination, I take up Jungblut and Rexe's (2017) argument that common, trans-domain goals and policy integration frameworks can take place either by blending existing policies, or creating a new policy framework (Jungblut & Rexe, 2017). Further, I consider that policy integration can be spurred on by through imposed structures (coercion), purposeful alliances (cooperation), or mutual adjustments (competition) (Benz, 2009). Here I present five promising practices for coordination at the federal, provincial and local levels which employ aggregation, comprehensiveness and consistency and explore the positionality and scalability of the coordination structures:

1. The Canadian Drugs and Substances Strategy (CDSS). The CDSS, led by Health Canada (2016a), presents as a promising practice as an example of a policy document at the federal level that aims to employ horizontal coordination mechanism. It enlists a host of diverse federal actors in pursuit of a common interest. Agencies including Canada Border Services, Canada Revenue Agency, Correctional Service Canada, Indigenous Services Canada,

[20] Comparisons between coordination models between sectors and jurisdictions are explored later in the comparative section.

Department of Justice, Global Affairs Canada, Parole Board of Canada, Public Health Agency, Public Prosecution Service, Public Safety Canada, Public Services and Procurement Canada, and the Royal Canadian Mounted Police are organized in this strategy in pursuit of a common goal of limited the negative societal impact of MHSUD in Canada. The document works through a shared vision and shared mandate across all stakeholders, the presence of all policymakers at the development stage, and measurable outcomes with reporting standards to ensure fidelity of implementation from federal stakeholders. However, insofar as the CDSS coordinates federal stakeholders and action, yet systems serving MHSUD responses are legislated provincially, there is a lack of multi-level coordination. In fact, a lack of multi-level actors at the plannings is a consistent theme in the federal data set where there is a trend of one-way dispersal of information to provincial bodies, sometimes along with funding transfers (PHAC, 2021b; HC, 2018; CCSA, 2022; CPHO, 2022; ISC, 2021). Given that each of the included federal stakeholders had previous mandates associated with MHSUD policy and legislation, this coordination effort appears to be a cooperative action to blend existing policies. As discussed in Chapter 6, the CDSS became a policy actor in and of itself, using a dedicated but dependent model, in which HC took the lead on a cross-sector strategy, while also being a ministerial actor within the broader strategy.

2. Select Standing Committee on Children and Youth (SSCCY). At the provincial level, the SSCCY in BC is another promising practice which catalyzes horizontal (provincial level) policy coordination through a committee structure, It puts forward vertical directives in support of achieving shared provincial-level interests. SSCCY was discussed earlier as a coordinating actor which takes on a dedicated but dependent model by working to create new policy frameworks through cooperative engagement. SSCCY includes cross-partisan

representatives from independent ministries in child-serving systems to respond to RCY recommendations and make recommendations. Fidelity of implementation is achieved through commissioned reports and ground-level inquiries with specialists, universities, and the public.

3. MMHA's *Planning for Hope*. Alongside the SSCCY—and indeed, formed as a result of SSCCY recommendations—the BC/MMHA's strategic plan, *Planning for Hope* (2019), is a promising practice as an exemplar of coordination which horizontally coordinates ministries of Health, Education, and Child and Family Development in pursuit of a common policy interest. As an imposed structure, the coordination mechanism here takes the form of coercion whereby BC/MMHA works to orchestrate both a shared vision and shared policy actions with all policy actors at the table, "across ministries, with Indigenous partners and service delivery partners [to] build a culturally safe and effective system of care" (MHA, 2018, p. 9). Within the strategy, outcomes and priority actions, including key actions for mental health in schools including integrated child and youth treatment teams, span ministries of BC/MH, BC/MCFD and BC/MECC. For example, BC/MCFD runs and funds youth mental health services, BC/MH runs school-based multi-disciplinary teams, BC/MECC coordinates the *Mental Health in Schools Strategy*. Each of these mandates is rooted in *Pathway to Hope* and vice-versa. Guiding documents speak to each other and are in line with BC/MCFD service delivery framework. Furthermore, the Tripartite Partnership to Improve Mental Health and Wellness (BC/MH) is supported by a *Memorandum of Understanding* which formally places Indigenous perspectives and values prominently throughout programming models. In terms of fidelity of implementation, the BC/MMHA strategy's structured work allows higher level governance to collect data at the grass roots

level to monitor actual impact. This strategy includes co-planning with Indigenous communities, bringing services and supports to families and caregivers and a three-year plan with defined actionable items across sectors are structures created. This is an example where policy document has a powerful role in guiding cross-sector and multi-level coordination.

4. Local Partnership Between Southern Chiefs Organization and MacDonald Youth Services. In Manitoba, SCO and MYS provide a promising practice of regional level horizontal coordination between service providers in lieu of higher-level orchestration and coordination. As discussed in Chapter 5, though provincial symbolic policy actions support cross-sectoral responses, there is a lack of provincial direction in linking social supports with MHSUD supports in Manitoba. Given this lack of high-level orchestration or policy integration, regional partnerships emerge. In this case, SCO and MYS commit to the following: "creation of a governance framework that is guided by the principles of reconciliation…[d]esigning and building a community care model consistent with the evolution of the child welfare system as contemplated by southern First Nations" (2023). This exemplar of coordination includes both policy actors at the planning stage, a shared vision for youth, a shared funding model, and evidence-based data collection at the grass-roots level. This seems to be in keeping with West et al.'s (2021) argument that in absence of meaningful policy integration at higher levels of governance, organizations tend to partner to deliver the right services as a grassroot initiative. While this exemplar of service coordination employs conditions for coordination, the location of this coordination at the service provision level—rather than at the higher legislative level—results in inconsistencies in the types of services and supports between local jurisdictions (Dunst & Bruder, 2006). As discussed above, inconsistent school-based partnerships with AFM (River East Transcona School Division, 2020), in-school

therapy provision (Norwest Hub, 2023), psychiatric nurses (Government of Manitoba, 2019) have been cited as exemplars of this same type of inconsistency.

5. Supporting and Connecting Youth: Substance Abuse Health Promotion Initiative in BC. The SACY is a cooperative arrangement formed through a purposeful alliance between the VSB, Vancouver Police Department, and VCHA. This strategy includes a shared strategic plan including tiered interventions where education, justice, and health care actors take on cross-sector coordination roles to support different needs of students. This partnership and the corresponding shared interventions include dedicated funding and dedicated staffing to support the initiative (for example, the VSB has created a District Principle of Mental Health). The lack of provincial policy actors at the table with these regional stakeholders is notable. There is no reference to BC/MCFD mental health supports for youth, and there does not seem to have been updates to the SACY initiative to account for recent provincial discussions of Integrated Child Youth Teams in all BC school systems once it is past the pilot stage (BC/MMHA, 2022).

Other exemplars of policy integration models presented in the Analysis section with some characteristics of effective coordination methods were noted, but were found to be lacking in either aggregation, comprehensiveness, or consistency. For example, though the JCSH, which utilizes a blended model in which ministerial actors work independently of each other, but towards synergy, is a cross-sector policy actor, it does not have mechanisms to monitor fidelity of implementation, nor does funding take place at the level of policy decisions. Similarly, BC's *Healthy Minds, Healthy People* (2010), a cooperative between BC/MH and BC/MCFD, demonstrates work undertaken to align mandates of BC/MH and BC/MCFD in pursuit of responsive MHSUD systems. However, this document really serves as a position paper

documenting the ways existing BC/MH and BC/MCFD supports are aligned in meeting MHSUD needs, rather than reframing supports or supporting coordination mechanisms moving forward.

If we look at the five promising practices or coordination relationships selected in this data set, one is federal, two are provincial (both BC), and two are regional (one BC and one Manitoba). The federal and provincial coordination relationships were coercive, that is, mandated externally to policy actors involved. Both of the regional examples were voluntary and collaborative. Notably, while all five promising practices show strong evidence of horizontal policy integration, only the BC/MMHA Strategic Plan and the SACY initiative also employ vertical orchestration of lower-level policy actors in pursuit of a common goal. The CDSS coordinates with federal ministries hosrizontally but vertical coordination with lower-level actors only take place via health care transfers in a single sector. SSCCY has strong coordination mechanisms, but by virtue of its role as a recommendation body, it is not positioned to do the work to actually prompt vertical policy alignment. In the case of the partnership between SCO and MYS, the policy partnership is strong, but it is positioned already at the service provision level, so does not have the legislative standing to prompt any further coordination. We, thus, see SACY and the BC/MMHA *Planning for Hope* strategy utilizing necessary tools for both horizontal and vertical coordination where service provision mandates directed out of a higher-level policy integration framework support a cross-sector coordination paradigm.

It is also noteworthy that, with the exception of the service partnership between SCO and MYS, each of these exemplars of effective coordination relationships are supported by one of the cross-sector policy actors discussed earlier in this chapter who are formally positioned to support coordination. **A key finding is that coordination between sectors is well supported by cross-sector policy actors at the funding level who can orchestrate goals, funding, strategic**

planning, and goal monitoring. In absence of trans-domain goals at higher levels of government, there is evidence of local level partnerships to take the leadership role and meet policy needs.

In response to the research question, "what are the interests, beliefs, policy actions, and coordination mechanisms that are implicit and explicit in these documents?", the data set shows fragmentation in both beliefs and policy responses. Notably, policy documents advancing socio-ecological models of health and therefore advancing coordination ideals are mired in competing (single sector) discourses and are most often relegated to symbolic, rather than material, policy actions. In the case of schools, discourses of safety most often trump discussions of socio-ecological health. The data set shows a lack of a national vision or strategy for MHSUD and in lieu of meaningful higher level MHSUD policy responses, local level innovation forges inconsistent coordination pathways.

Research Question 3: Documented Impacts of the Current Policy Landscape for Youth in both Jurisdictions

Many of the documented impacts of the current policy system on youth with MHSUD included discussion of logistical shortcomings. For example, a lack of availability of services, waitlists, and systems that are difficult to manage. In fact, both Manitoba and BC share concerning statistics about the number of youth that require MHSUD care, and the number of youth that are able to access MHSUD care in current frameworks. In Manitoba, Virgo Reported that though 29, 512 youth are in need of MHSUD services, the provincial capacity to help youth recover is only 15,960 (Virgo Report, 2018). That means meeting the capacity is 54% of existing needs. In BC, in 2017 RCY received 154 substance-related critical injury reports, which was

nearly double the 78 reports received in the previous year (RCY, 2017). MACY (2021) argued that an increase in drug use has not been paired with an increase in services. And, as the MHCC (2021) noted, without federal funding of mental health at parity with physical health, public supports funded by donors and partnerships have small capacities resulting in waitlists. MACY (2022) presented data demonstrating that without a provincial, child-specific mental health strategy, mental health resources are not well matched with youth need, resulting in gaps in the system and youth who are suffering. In BC, RCY argued that not only are there gaps in the system, there is "the absence of an actual system with no single entity responsible for MHSUD" (2016a, p. 12). Since 2016 significant resources have been put into place to support a cross-sector youth mental health strategy in BC. RCY (2022) argued that while substantial progress had been made, outcomes for marginalized youth (youth in care and homeless youth) were still poor. Beyond these logistical and capacity concerns, key themes related to the impacts on youth include: 1) eligibility criteria as a barrier and value position; 2) policy actions rooted in an over-reliance on last-hope responses; and 3) a shared need for coordination with community based, culturally responsive, and school-embedded supports. Each of these categories are explored in more detail below.

Eligibility Criteria as a Barrier and Value Position

A key theme in the combined data set of media, MACY, RCY and MHCC documentation was the role of eligibility and ineligibility for youth in accessing MHSUD supports. Advocates argued that inherent value judgements restrict: (a) who can or cannot access services; and (b) the types of services that are offered in a policy context. For example, restricting access to youth based on ongoing substance use was a common theme across jurisdictions (MM11, MM13,

MM14, MBC14, MACY 2021b, MACY, 2018, RCY 2020, RCY 2019) and highlights the ways stigma surrounding substance use continues to separate youth from care. Additionally, a theme of offering services that align with system-determined preferences rather than youth needs was associated with systems in which youth are deemed resistant to services, rather than considering whether services meet youth needs, again locating the problem within the child themselves (MM5, MM9, MBC2, MBC14, MACY2021b, MACY 2020a, MACY 2020c, MACY 2018, RCY 2018, RCY 2015). This includes a lack of culturally diverse and culturally responsive care options (MBC1; RCY, 2022, MACY 2021b). From a broader system-level perspective, the MHCC, by virtue of its advocacy for congruence between physical health and mental health funding, noted that MHSUD services are not covered by health systems unless offered through hospital (2022). This results in a system in which those who have means to pay for services have increased access over others. This data set shows that value judgements about who can access and how they can access supports result in hesitancies to implement non-restrictive supports including open-door policies (MACY, 2020c), treatment of concurrent disorders (RCY, 2019), harm-reduction strategies (MM13), preventative programming for youth in care (RCY, 2022), and culturally reflective care (MACY, 2021b) in the broader landscape of MHSUD responses.

RCY argued that supports and services must meet the needs of marginalized youth rather than inaction that serves to "normalize unacceptable outcomes" (RCY, 2016 p. 51). In Manitoba, the dual declarations that there is only 50% capacity for existing MHSUD needs (Virgo, 2018) but that (b) the two most prominent residential treatment facilities, Shared Health's Compass Program and WRHA's Youth Addiction Stabilization Unit, are at 27% and 44% capacity respectively suggests a strong mismatch between needs and supports. For example, Compass eligibility requirements include having a "place of residence upon discharge," not presenting

"physical, medical or psychological needs beyond the program's capacity" and not being "under the influence upon arrival" (Compass, 2023) while families are told youth are "resistant to services" (MACY 2018, 2020c). These criteria suggest that value positions of blame are being utilized rather than value positions which explore treatment paradigms that will meet the needs of youth. **In sum, data show that existing eligibility criteria in the Canadian provincial context is positioned as a gatekeeper to restrict services. Furthermore, data suggests that ingrained value positions about youth sometimes become a barrier to accessing services, and that non-participation in services often results in blaming the youth rather than re-imagining supports.**

Over-Reliance on Last-Hope Supports

Existing policy actions in both provincial jurisdictions have included development of intensive, last-resort policies—that is, policies that inform what to do when all else has failed. A consistent theme in the examined data set is a documented over-reliance on policy actions and support paradigms positioned as last-hope, intensive support options in lieu of a proper continuum of supports that were able to match youth need with timely and appropriate responses. These last-hope options included involuntary detention and detox (MM10, MBC5, MBC6), school disciplinary strategies centered around suspension and expulsion (RCY, 2018; MACY, 2019), involuntary hospital treatments (MACY 2020b, RCY 2021), referral to justice-based and probation responses to access treatments for youth (RCY 2016b), and referral to child welfare involvement (MACY, 2021d) for youth MHSUD. RCY (2016b) argued that in the case of youth with profound needs, there is a lack of "robust services and residential treatment options" (p. 53). **Over-reliance on last-resort exclusionary, involuntary, and punitive responses takes place**

in the both the Manitoban and the BC contexts. In Manitoba, there is evidence of the lack of a proper continuum of tiered supports which would meet youth needs and have the ability to scale up or scale down supports as needed.

Coordination for Community-Based, Culturally Responsive, and School-Based Supports

The data set reflecting youth in both jurisdictions includes youth advocating for accessibility of MHSUD supports via coordination with community organizations, hub access points, schools, and keeping with Indigenous knowledges. Youth voices in support of meaningful coordination for culture, access, and alignment echo much of the federal policy papers (PHAC, 2022; 2021a; 2019a) which call for alignment of services to support youth MHSUD in communities, cultures, and schools.

Coordination with communities. Calls by youth and advocates to locate MHSUD services in community was a strong theme in the policy review where youth called for increased social supports for homelessness associated with MHSUD (RCY, 2020), increased recreational activities that meet youth where they are (MACY, 2021b, MBC10), and increased community-based programs that include social and vocational supports (MBC3). MACY's call for "systemic enablers of wellbeing" (2021b, p. 24) that support healthy families in the community is thus a shared goal of youth. The call for community coordination and shared participation in MHSUD supports is situated alongside a documented lack of access of health-based supports for youth MHSUD in Manitoba (Virgo, 2018) and health and social-based youth MHSUD supports in BC (RCY, 2017). Thus, expanding supports to improve access presents as a vital move forward. Furthermore, if we consider the promising practices supporting coordination reviewed earlier, it is also noteworthy that legislation-level policy integration to support local level service

coordination would result in more consistency in service provision. Therefore, there are strong data to support these "systemic enablers of wellbeing" at higher levels of governance as a means to supporting consistency in service-level community coordination.

Coordination to support culturally relevant responses to MHSUD. In both Manitoba and BC, access to traditional teachings, cultural practices, and healing practices for youth requiring MHSUD supports had significant barriers (MM7; RCY, 2022). MACY argued that "discrimination and racism against First Nations boys can become barriers to the realization of their fundamental rights to receive culturally safe and supportive services" (2021, p. 7). Across the data set, the over-representation of Indigenous youth requiring MHSUD supports is well-documented[21]. In Manitoba, a strong theme in the Virgo Report's data regarding provision of culturally relevant services to Indigenous populations was the shortage of appropriate supports including, "the lack of cultural based services…. [L]ack of knowledge/awareness/sensitivity to cultural issues/needs…[And] need for cultural safety (Virgo Report, 2018, p. 93). In BC, despite recent work to tailor MHSUD supports to youth populations, marginalized youth such as Indigenous youth, youth in care, and most prominently, Indigenous youth in care, continue to be under-served with appropriate supports (RCY, 2022).

Coordination with schools. There is a consistent call from youth and youth advocates in both jurisdictions of Manitoba and BC to not only ensure schools support youth with non-exclusionary practices, but also to locate supports for MHSUD in schools where youth are each day. A University of Manitoba research team argued that primary prevention programming in schools is vital to social-emotional development of youth (CBC News Team, 2018). However, beyond primary prevention, youth advocate for more supports for MHSUD in schools, beyond

[21] Comparisons of coordination with Indigenous peoples and incorporations of Indigenous perspectives between jurisdictions will be examined in Section 6.4,

simply drug education (MM19; MBC9; RCY, 2018). The RCY, for example, calls on "MCFD, Ministry of Education, Ministry of Health to co-locate mental health and substance use services in BC schools to increase the ability of youth to engage with services and to help support early identification and intervention" for MHSUD problems (RCY, 2016, p. 5). And in this same vein, SSCCY identified schools as "primary location for [MHSUD] service delivery" (SSCCY, 2016, p. 20). Across both jurisdictions, youth call for a reliance on strategies beyond suspension to work with youth with ongoing drug and alcohol concerns (RCY, 2018). **In sum, community-situated, culturally relevant, and school-based support services are in alignment with federal policy direction and youth advocacy around MHSUD and yet are lacking provincially.**

In response to the research question, "what are the documented impacts of the current policy landscape for youth in both jurisdictions?", the data set shows a lack of availability and persisting stigma in MHSUD supports. In particular, eligibility criteria are often not aligned with need, and an over-reliance on last-hope supports exists in absence of a tiered continuum of supports. The result is that youth are not able to access the services that they need. Though community-situated, culturally relevant and school-based responses align with federal directives, they are lacking provincially.

Research Question 4: Documented Values, Policy Actions, and Coordination Mechanisms Compared between Levels of Government, Sectors, and Jurisdictions?

In this section, I use comparative analysis to investigate the ways in which responses to youth MHSUD compare between levels and sectors of governance (both within federal and provincial levels) and between jurisdictions (BC and MB).

Comparisons in MHSUD Responses Between Levels of Governance

As explored throughout this thesis, the constructs of federalism have a profound impact on the ways in which different levels of governance respond to MHSUD. At the federal level, we see three key trends with regards to policy actions to guide responses between levels of government to youth MHSUD: 1) symbolic policy actions in the form of advocacy work; 2) material policy in the form of funding transfers from HC; and 3) material policies in the form of pilot projects[22]. Despite the fact that HC has not addressed the "growing need for broader health insurance by making coverage for non-physician health and mental care providers… a condition of federal funding transfers" (Witkorowicz, 2019, p. 16), document analysis shows that *some* health care transfers are mandated to support MHSUD at provincial and local levels (HC, 2022). It seems that in the absence of being able to direct MHSUD responses through material policies, the federal government has placed an emphasis on policy papers which position schools as central to MHSUD strategies but which leapfrog ministerial systems. Considering the identified key qualities to support coordination, the federal recommendations to regional actors included no additional funding to support new initiatives, do not include inviting all policy actors at the table, and have no way of gathering grass-roots information from local and regional actors to assess and strategize next steps or supports. That is, federal coordination skips a step and local policy actors may choose to, or not to, pick up on the recommendations. At the same time, pilot projects clutter existing service delivery frameworks and result in short-term strategies that may not be aligned with provincial ministerial values and mandates.

[22] As examined above, the Canadian Drugs and Substances Strategy is an exemplar of a coordination mechanism to employ horizontal coordination, but by virtue of its engagement with federal offices only, and with little work to facilitate vertical coordination with provinces who actually legislate MHSUD responses, though it does present a promising practice for coordination, it does not direct responses to youth MHSUD.

Provincially, ministries of education, health, and social services are entrenched in past practice. This occurs both due to the history and strength of the ministerial system, but also "because mental health and substance use have never been a priority of any provincial government, services today are fragmented and lack consistency and oversight" (BC/MMHA, 2018, p. 2). In the data set as a whole, the analysis showed how provincial policy direction is mired in isomorphic responses of single-sector mandates except when a coercive enforcer pushes ministerial actors out of their path-dependent models. The analysis demonstrated that coercive enforcers prompting cross-sector collaboration and shared goals in the data set include federal funding transfers conditional on new policy actions (for example, JCSH, Public Safety pilot projects, HC transfer payments); coordination bodies which legislate cross-sector collaboration (for example, MHAA, SSCCY, Healthy Child Manitoba); and provincial cross-sector funding models mandating funding for regional actors (for example, MB/ME, MB/MMHCW's pilot project with nurses in schools).

Regional actors are subject to federal and provincial legislation, directives, and guidelines and generally take on the work of applying policy to provide services in real time and with real people. As shown in the analysis, this is increasingly taking place with cross-sector mandates rooted in socio-ecological health discourse, but oftentimes without proper coordination mechanisms provincially to support those mandates. Without adequate policy coordination efforts at higher levels of governance, regional bodies are often forced to form policy collaborations and service provision pathways without provincial guidance. In this data set, fragmentation in cross-sector policy interests, actions, and coalitions regarding MHSUD between levels of governance results in inconsistencies in service and coordination at the grass roots level. **Shared cross-sector policy interests, actions, and coalitions regarding MHSUD at**

provincial and federal levels were associated with more equity in coordination mandates at the regional levels.

Sectored Comparisons of MHSUD Responses

When we consider sectored responses to MHSUD, we see some notable differences both in terms of mandates and in service delivery frameworks. In the case of health, there is a strong diagnosis and treatment paradigm rooted in triage systems. For example, across levels, MHSUD is referred to as a condition that can be "managed and treated" (HC, 2018, p. 4); a condition to be "managed" (MB/MMHCW, 2022d), and listed alongside physical health as shared health mandate (SH, 2023). In Manitoba, treatment of MHSUD as a biomedical issue is the only visible discourse used by the ministry of the MB/MHHLS. This emphasis on triage, diagnosis, and treatment seems to feed into a conflation of narratives where policy actions in support of MHSUD tend to be focused on health care restructuring. This becomes evident when MHSUD is stated to be supported by a "restructure of all related services and that regional hubs…be identified hospitals" (SH, 2019b, p.18). Certainly, there is need for medical diagnosis and treatment for MHSUD, and a move away from solely safety-based responses has been a progressive move to support those with MHSUD rather than blaming them. The fact that medical responses to MHSUD are the dominant discourse of intent associated with material policy actions in the data set indicates that MHSUD has been entrenched in health care models. However, insofar as a solely medicalized model can work to ignore the social, familial, and cultural positioning of individuals, the work of other sectors ought to also be part of the equation.

In the case of social services provision, provincial ministries hold the bulk of the control. In the Manitoban context, the MB/MF has a singular mandate related to the protection of

children and support for families. BC/MCFD has a dual mandate including: (a) protection of children and support for families; and also (b) provision of youth mental health services. This means that in the BC jurisdiction, there is key oversight via social services to intervene in matters of languishing youth mental health. In the Manitoban context, on the other hand, mental health is rarely named in the policy documentation and is instead pulled along by discourses of health care provision where there is a mandate to provide appropriate health care for youth (MB/MF, 2022). However, despite BC/MCFD's role in supporting youth MHSUD supports, RCY (2022) argues that the CFS Act itself does not specify mental health as a service mandate for youth in care, which results in social workers trying to work within mandates for health care provision to provide supports. In BC, there is work being undertaken to include MHSUD as a service mandate within the CFS Act. However, this positioning of social workers without a direct mandate for MHSUD service provision is the same as in Manitoba.

Education's mandate can be considered broadly as supporting the growth, development, and learning of youth. Many advocates and stakeholders have remarked in the key and important positioning of schools to implement education (MACY, 2021), prevention (PHAC, 2019a, 2019b, 2019c), screening (RCY, 2022), triage (SSCCY, 2016), and service provision (MHCC, 2013) for MHSUD. Despite this, the MHCC argues that there is a lack of a common vision across initiatives for MHSUD in Canadian schools (MHCC, 2013). Further, data indicate that the emphasis in school board policy continues to be on intervention services and disciplinary actions for high needs students, rather than on mental health promotion and prevention (MHCC, 2013). That is, data show that the full continuum of care is not being addressed in a proactive, even manner. The MHCC argues that there is a lack of integration and common vision across initiatives for MHSUD in Canadian schools (MHCC, 2013). Certainly, this reality is reflected in

this data set, in which BC's jurisdiction includes a mandate to address youth MHSUD provincially and regionally, including partnerships with other sectors. Manitoba's data set shows an unwillingness to even mention MHSUD overtly, and instead clouds it with discussions of "belonging," "wellbeing," and "appropriate programming" (MB/ME 2017, 2022).

MHCC (2013), CPHO (2018), PHAC (2021), CCSA (2017) and JCSH (2023) all argue for the necessity of schools to deliver coordinated, evidence-based strategies across a continuum of care. This includes social skills training and social emotional learning, school-based cognitive-behavioural programs, prosocial skill development and professional development for educators (MHCC, 2013). However, envisioning education as solely a preventative actor seems to ignore the positionality of schools in a broader system. Notably, both the RCY and MACY have emphasised that in lieu of appropriate tiered planning for MHSUD by health, sectors without waitlists—primarily schools—are left to pick up the slack (MACY, 2020a; RCY, 2019). This is in keeping with Mainz's (1997) argument that policies of one department can create negative spillovers into other departments, creating a "management of interdependencies" (p. 272) to overcome resultant policy outcomes. While RCY and MACY list social services and justice sectors, they under-represent the difficult role that schools take on with programming and supporting youth and families with a continuum of needs—not just preventative needs—in absence of comprehensive supports.

In sum, though the health care sector has most prominently taken on responses to MHSUD, socio-ecological health discourses have resulted in inconsistent permeation of MHSUD responses into sectors of social services and education. In the Manitoban context, neither provincial Ministries of health or social services have clear mandate on MHSUD directly. Both health and social services have the ability to schedule or waitlist responses for youth, while

education is unique in its positionality as a daily provider for youth in general, including youth with MHSUD. **That is, while a continuum of care for MHSUD spans across ministries, embracing of this framework outside of Ministries of Health has been slow. Education is unique in its positionality as a daily provider for youth and thus policy learning to elicit a continuum of care that extends into school systems and schools themselves is important.**

Jurisdictional Comparisons of MHSUD Responses

In this section, I compare intents (interests and beliefs), policy actions, and coordination mechanisms in the Manitoba data set alongside the BC data set.

Policy Interests and Supported Beliefs in Compared Jurisdictions. As discussed above, in the last decade, there have been shifting value positions at federal, provincial, and regional levels with moves to embrace MHSUD as rooted in understandings of socio-ecological health, and therefore, in need of cross-sector approaches. This has included supports embedded in schools (Thomas et al., 2020), social systems (Liddle et al., 2019), and community health care (Morisette et al., 2009); with focus on cultural and spiritual support (Maar et al., 2009) and strong families (Filges et al., 2019). Inquiries into policy landscapes can serve to "[examine] assumptions, surfacing challenging mental models and acting on what is learned" (Boyce, 2003, p. 128). Policy learning takes place when a dominant coalition sufficiently changes its secondary beliefs, meaning policy preferences are employed to solve a policy problem. In the case of the MHSUD policy subsystem in Manitoba, we see policy learning whereby the secondary beliefs—that is, the disourses of intent and the policy interests that frame how we ought to respond to the policy problem of MHSUD—that mirror those at the federal level and in the jurisdiction of BC. A key indicator of the growth of this understanding of MHSUD has been the infiltration of a

discourse of cross-sector response to MHSUD at key policy-making junctures, most notably, the federal offices of CPHO, CSSA, MHCC, PHAC and provincial ministries of mental health. When we investigate the embracing of cross-sector responses as a particular discourse of intent in the Manitoban context as compared with the BC context, the analysis suggests some notable differences.

In Manitoba, a discourse of intent of applying cross-sector approaches to MHSUD was evident in documents supported by MB/MHCW, AFM, CPHO and Virgo Planning. Provincial Ministries of education, health, and families did not support this discourse of intent and instead utilized discourses that aligned with traditional ministerial boundaries, grounded in the idea of safe schools, biomedical service provision, and social supports, respectively. In Manitoba, the most dominant discourse of intent is that of medical service provision for MHSUD. I have argued above that the dominance of this discourse of intent may be tied to recent provincial health care restructuring. Indeed, there are a plethora of examples in which stated values in support of changes to MHSUD responses have been conflated by health care restructuring (SH, 2022). At the regional level, examination of data showed Manitoba had an abundance of service provisions and biomedical responses. Notably, in the education sector the policy silence in the form of a lack of overt mention of MHSUD exists both provincially and regionally. In the social services sector, however, the policy silence at the provincial level is not echoed at the regional level or cross-sector level. Harm reduction supports for MHSUD also broke out of traditional ministerial boundaries intent on providing social supports. It is also noteworthy that in the Manitoban policy landscape, there has been an unwillingness to use the word “addiction” in the ministerial title, as the BC ministry has, though this has changed with a 2023 change in provincial government. This suggests ongoing policy learning about the nature of substance use

(and a re-evaluation of deep-core beliefs) and shifting policy interests and secondary beliefs about how to respond to MHSUD.

In BC, discourses of intent focussed on establishing cross sector frameworks for MHSUD and multi-modal service provision for MHSUD are dominant in documentation across stakeholder groups: BC/MCFD, BC/MMHA, BC/MECC, FNHA, BCPHA, while discourses of intent stemming out of a single sector were rare. At the regional level, the values present in the data set reflect this provincial-level cross-sector and harm reduction lens in health and education documents (VCHA, FNHA, VSB). **In sum, comparing the Manitoban and BC data sets, discourses of intent at the provincial level focussed on cross-sector planning and service provision in BC were correlated with cross-sector interests and beliefs about MHSUD at the regional level. By comparison, provincial discourse of intent drawn out of isomorphic ministerial boundaries in Manitioba were correlated with a lack of cross-sector and socio-ecological interests at the regional level, with an inconsistent adoption of such values.**

Policy Actions in Compared Jurisdictions

A key difference emerging from the comparison between the Manitoban and BC jurisdictions is in the material enactment of symbolic policy goals. Though both Manitoba's and BC's key symbolic and strategic planning documents (Virgo, 2018; MHCW, 2022; MMHA, 2019; SSCCY, 2016) share a commitment to cross-sector responses to MHSUD which focus on harm reduction and understandings of socio-ecological health, the material policy actions in child-serving ministries differ.

Positioning of the Ministry of Mental Health. Both Manitoba and BC have provincial ministries of mental health, and both ministries hold a mandate to consider, inform, and legislate

provincial responses to MHSUD. In both provinces, there is a strategic planning document which serves to organize and share legislative goals with the public, and also with other ministerial actors through its mandates. In BC, the strategic planning document takes on an orchestrative role in which long term and short-term goals, measurable outcomes, and clear engagements with other ministerial sectors are laid out. For example, the strategy includes concrete list of actions such as the development of Step-up/Step-down beds for youth in health care facilities, and the establishment of Integrated Child Youth Teams in schools with timelines scaling up each of these material policy actions (BC/MMHA, 2022). Manitoba's *Pathway to Mental Health and Community Wellness* document, by comparison, serves as a commitment to a course of action rooted in socio-ecological values, but does not take on an orchestrative role (MB/MMHCW, 2022). For example, the document references the need to forge partnerships with education and social services, but without a clear action plan that would include social services and education input in development of the document mandate or plan. If we consider the fact that the BC ministry strategic plan pre-dates the Manitoban ministry by six years and was also preceded by a 2010 BC/MH and BC/MCFD cross-sector strategy, it may be that the Manitoban response is still in a process of deciphering and sharing goals and mandates. The mandates and actions of **cross-sectorial ministries, designed to support MHSUD responses provincially, vary in their orchestrative roles and impact. Whereas BC's ministry takes on an orchestrative and strategic planning role, Manitoba's ministry has taken on a vague goal-setting role.**

Consolidation versus multiplication of policy responses. Manitoba's embracing of a MB/MMHCW was undertaken synchronously with a health care reform mandate in 2021. This results in some entanglement of provincial MHSUD goals with health care reform goals (SH, 2022). In general, in Manitoba, the move to have MHSUD managed provincially by SH was an

answer to criticisms that existing access points for MHSUD care were redundant and confusing. In response, a key policy action in the Manitoban sector was a reduction in the number of stakeholders and access points (SH, 2023). BC, by comparison, has advanced a MHSUD mandate through a multiplication of services in a multiplication of ministries and ministerial actors, including BC/MCFD, BC/MECC, BC/MH, BC/MMHA, VSB, VCHA and FNHA. While the range of access points has increased for BC, it presents some confusion with regards to policy mandates. For example, BC/MH and BC/MCFD both offer service provision for MHSUD supported by regional actors including health care authorities (BC/MCFD, 2019, BC/MH, 2022). At the same time, school-based partnerships with service providers such as RHAs allow for referrals to private service providers (VSB, 2023). In line with the BC/MMHA goal that "every door is the right door" (2018, p. 12), it follows that this proliferation of access points and service provision is in keeping with their mandate. However, it may also be that there is confusion in how to navigate the system as Scharpf (1997) has argued. That is, though a chief strategy in Manitoba is a consolidation of access points, this conflating of MHSUD provision with service delivery is not seen in the BC jurisdiction. **In sum, though there is pan-national agreement about the need for improved MHSUD supports for youth, policy actions in different jurisdictions are employing starkly different tactics in an absence of best-practices for provincial models.**

Storylines of control and of reform. As analyzed in Chapter 5, policy actions employed in the compared jurisdictions, and the narratives around these policy actions, contributed to a storyline of control in the Manitoban subsystem, and a storyline of reform in the BC subsystem. Analysis of policy actions and analysis of media coverage of these actions in the Manitoban jurisdiction included declarations that the natural policy path was to "stay the course" and to

continue with existing policy models. This was evident in media reports in which concerns raised about the efficacy of MHSUD programming in Manitoba were followed by a statement from the provincial government outlining what policy actions have already been taken and reassuring the reader that the policy problem is under control (MM1, MM5, MM7, MM13, MM16, MM20). It was also evident by an adversative relationship with MACY in which MACY recommendations prompt reports by deputy ministers defending past actions and declaring new ones (MM4). There was also a trend of meeting questions and concerns with reassurances of existing legislative supports (MM2). The aforementioned conflation of MHSUD responses with health care restructuring where broad concerns regarding appropriate service provision were boiled down in responses tied to logistic control, including triage mechanisms, health care funding, and access point restructuring (Shared Health, 2022) were also present.

In BC, by comparison, analysis of policy actions and of media coverage of these actions showed a willingness to state and document decline and to implement changes to the existing policy landscape. This was seen in media stories which included government officials responding to critique with re-evaluation (MBC6) and revisioning (MBC5) of legislated MHSUD responses. It was also evident when RCY reports were shared with SSCCY with a mandate and an operational norm to investigate via cross-sector and cross-partisan inquiries and reports the context for RCY recommendations prior to making recommendations to respective ministries (Government of BC, 2015). In general, the storylines of control centred around defending actions in MB, and storylines of reform centred around exploring new actions in BC. **Shifting the narrative beyond a control-based one in the Manitoban context could serve as a catalyst for new reform-based storylines.**

Involuntary holds as a litmus test. One key policy decision that acts as an indicator of values and an exemplar of storylines of control and reform in the compared jurisdictions is the issue of involuntary holds. The analysis shows strong advocacy via media reports and MACY reporting to increase involuntary hold options for Manitoban youth (MACY, 2023; MACY 2021). On the other side of the spectrum, the BC data set showed advocates, media reports, and the RCY advocating against the use of involuntary holds (RCY, 202x; RCY2016b). Notably, the arguments for and against increased in involuntary holds are similar in nature with both jurisdictions calling for an increase in intensive options—within a multi-tiered system of sypports—to support youth. However, Manitoba's response is to increase control in lieu of additional intensive supports while BC's response seems to be to decrease control-based responses. In the case of these two jurisdictional exemplars, Manitoba's increase in involuntary holds seems to correlate with the storyline of control, discussed above, in which there is a reduction of access points and policy actors, with a focus on single-sector policy responses. Similarly, BC's removal of a longstanding control-based support in an effort to alter policy pathways seems to correlate with a storyline of reform situated in an increase in policy actors, access points, and cross-sector policy actions. **Calls for increases for involuntary holds in the Manitoba jurisdiction can, thus, be seen as evidence of: (a) a control-based narrative, and (b) an indicator of a lack of appropriate tiered interventions for youth MHSUD. BC's more progressive approach which seems to be rooted in an attempt to bolster a spectrum of tiered responses and to distance control-based narratives may offer a promising path forward.**

Multi-tiered policy actions. As discussed above, there is consensus across levels of governance, in advocacy groups, media reports, and in youth documentation that a multi-tiered

systems of support with a continuum of responses for MHSUD are an evidence-based framework which would support youth with MHSUD best (Chafouleas, et al, 2020). Comparisons between the jurisdictions of Manitoba and BC show some key differences in the tiered responses that emerge out of policy actions in the two subsystems. Table 6.1 outlines identified material policy actions from the examined data set for the provincial and regional jurisdictions of Manitoba and BC. Furthermore, in this table I place policy actions in general tiers of response, based on whether they are: (a) a universal or prevention-based support; (b) a targeted intervention intended to provide treatment in community and out-patient settings; or (c) an intensive intervention which requires hospitalization or inpatient care.

Table 6.1
Existing Tiered Policy Actions in Manitoba

Tier of Support		Tiered Policy Actions
Universal (Primary Prevention)	Provincial	• Funding to United Way for community programs and Youth Hubs (MMHCW) • Funding to Strongest Families Institute (MMHCW) • Health care realignment to consolidate access for MHSUD (SH) • Prevention-based resources for educators via Health Curriculum (ME)* • *Healthy Schools* Grant (ME)* • Guidelines for planning inclusive schools: *Planning for Safety and Belonging* (ME)* • Mandate regarding professional obligation of social workers, Standards document (MF)
	Regional	• None identified
Targeted	Provincial	• Health based access points for MHSUD triage (MHHLS, MMHCW) • Provincial funding to Substance Use Services – previously AFM (Shared Health) • 3 jurisdictions with psychiatric nurses and wraparound programs in schools (ME)* • Funding to independent social programming organizations (United Way, Strongest Family Institute) (MMHCW) • Code of Conduct for school responses to substance use (ME) • *Standards for Appropriate Educational Programming*: services for youth with additional needs (ME)*
	Regional	• SCO's partnership with MacDonald Youth Services (SCO) • WSD partnership with Jordan's Principle to fund youth services (WSD)* • Student support services for youth with additional needs*
Intensive	Provincial	• Provincial funding to addiction treatment centers and naloxone programs (MMHCW) • Legislation for the involuntary admission in mental health facilities (MH) • Apprehension orders for the youth Addiction Stabilization Unit (MF)
	Regional	• None identified

** denotes supports are interventions that take place in schools or with support from schools*

Table 6.2 outlines the same data for the provincial and regional jurisdictions of BC.

Table 6.2
Existing Tiered Policy Actions in British Columbia

Tier of Support		Tiered Policy Actions
Universal (Primary Prevention)	Provincial	• Mental Health in Schools Strategy (ME)* • ERASE Strategy (ME)* • Standards for social work with youth to support services matched with student need (MCFD) • Expansion of funding to preventative care providers (MMHA)
	Regional	• Free wellness and mental health programming for Indigenous youth (FNHA) • SACY Substance Use Strategy (VSB, VCHA, Vancouver Police)*
Targeted	Provincial	• Integrated Child and Youth Teams in select jurisdictions (MMHA)* • Expansion of funding to virtual and Indigenous care options (MMHA) • Youth mental health services (MCFD) • Funding to service providers including Kelty Health and Foundry Centers for service provision (MMHA) • Code of Conduct for school responses to substance use (ME)*
	Regional	• Direct partnership for service provision with Kelty Health and Foundry Centers for service provision (VSB)* • Student support services for youth with additional needs (VSB)* • Youth Comprehensive Assessment and Treatment program (VCHA)*
Intensive	Provincial	• Step-up/Step-down beds • Overdose prevention and recovery options • Involuntary Admissions criteria (PHA)
	Regional	• None identified

** denotes supports are interventions that take place in schools or with support from schools*

When we compare material policy actions in the forms of supports and interventions for youth MHSUD between the two jurisdictions, some key differences arise. In BC, there is evidence of material policy actions in the form of multi-tiered supports for youth, out of all four ministries: BC/MCFD, BC/MECC, BC/MH and BC/MMHA and the regional organizations (VCHA, PHA, FNHA, VSB) that fall under them. BC's universal or primary prevention programming for youth is overseen by ME via *The Mental Health in Schools Strategy* (2022). At the targeted and intensive levels, BC/MH, and BC/MMHA support Integrated Child Youth Teams in schools deploy medical professional teams to identified school systems for triage and support at the school level (BC/MMHA, 2021). Support provided include Step-up/Step-down beds so that youth with complex needs can quickly be triaged to higher or lower-intensity

medical or school/community supports (BC/MMHA, 2019). BC/MCFD also runs MHSUD programming in the community whereby Child and Youth Mental Health Teams "provide additional services in the areas of prevention, risk reduction, community education, and consultation, and work in collaboration with other service agencies to ensure services are appropriate, culturally relevant and safe" (BC/MCFD, 2019, p. 12). That is, in the BC policy subsystem with the symbolic policy goal of "creating a seamless system of care from mental wellness promotion to highly specialized services" (BC/MMHA, 2021, p. 18), there is evidence of material policy actions to support this goal of MTSS supports with provincial direction.

In Manitoba, by comparison, we see a less robust continuum of supports, owed in part to the fact that the bulk of the tiered policy actions are drawn out of either MB/MHHLS or MB/MMHCW and are generally routed through the existing health-care system. For example, provincial funding to social programs is funded through MB/MHHLS or MB/MMHCW (MB/MMHCW, 2023) and funding to psychiatric nurses in three small rural school divisions also comes from MHHLS (Government of Manitoba, 2019). Though there are education and CFS standard documents that serve as guidelines for appropriate and inclusive programming and/or appropriate social service provision, these are not direct interventions specifically for MHSUD. Furthermore, given the heavy emphasis on a continuum of services being offered through the health care system, there does not seem to be a demonstrated emphasis on growth of services across tiers. For example, Shared Health, in an audit report, finds that "investment in public health and mental health and addictions are the two most critical challenges for Manitoba with the greatest return on investment" (Shared Health, 2019, p. 28). However they also find that "the infrastructure inadequacy that still requires correction is the increased emergency department capacity for mental health patients including locked units" (Shared Health, 2019, p.

24). **That is to say, despite a less robust continuum of supports in the Manitoban subsystem, there remains a focus on intensive and involuntary supports for MHSUD in this policy subsystem with continued gaps in universal and targeted support offerings.**

Multi-tiered supports in schools. When it comes to continuums of tiered supports in schools, we see a smaller number of interventions across the tiers in the Manitoban system compared to BC. While universal and preventative efforts exist in Manitoban policy, they are general strategies to support safety, belonging and wellbeing (MB/ME, 2018) with the exception of the health curriculum, which specifically deals with MHSUD information and prevention topics (MB/ME, 2023). At the targeted and intensive levels in schools, aside from a pilot project, provincial and regional direction stops at the administration of appropriate educational programming (ME, 2022). The BC data set in comparison shows a wide range of initiatives for MHSUD policies in schools including the Mental Health in Schools Directive (BC/MECC, 2020) and the ERASE strategy (BC/MECC, 2023). Also VSB's Substance Use Health Promotion Initiative in partnership with the VCHA (VSB, 2023), which includes both universal supports and targeted Comprehensive Assessment Teams, alongside other targeted supports for appropriate educational programming and referral to specialized services (VSB, 2023). In sum, in Manitoba, there is a comparative lack of supports for schools by regional and provincial governance bodies. In lieu of top-down direction and policy pathways, this leaves both the organizing of supports and the administration of supports up to schools themselves who end up being all things to all people.

Certainly, this is not to say that the BC jurisdiction has it all figured out in terms of continuums of support. Indeed, RCY advocates strongly that there remains an absence of appropriate supports and an over-reliance on intensive supports in the BC subsystem. However,

what we do see in the BC subsystem is the presence of all sectored stakeholders at the policy-making table focused on supporting continuums of support in schools. **In the Manitoba context, we do not see the presence of all sectored actors supporting universal and targeted supports in schools, and furthermore, we see a lack of universal and targeted supports from the provincial and regional education actors as well.**

Responses to over-reliance on suspension. As noted, schools are oftentimes required to be all things to all people by virtue of their open doors policy and mandate to support the education and wellbeing of all youth. Given calls for schools to act as "systemic enablers of wellbeing" (MACY, 2021, p. 24), federal calls to have education support MHSUD (PHAC, 2021) and the Virgo Report's claim that education stakeholders are vital to MHSUD system of supports, it is clear that there is large-scale support for schools to employ supportive and restorative responses for MHSUD rather than punitive ones. At the same time there are calls to disempower zero-tolerance responses to substance use in schools and concerns with the over-use of suspension for MHSUD concerns, prominently emerging from the analysis (MACY, 2018).

However, the emphasis on removing suspensions in schools is not simply a matter of eliminating a strategy. Insofar as schools are in the position of needing to support and program for youth with intensive needs and support families, all while ensuring school safety (MB/ME, 2018; MB/ME, 2016), suspension is utilized as a last resort when other school-based strategies have been deemed ineffective and when there are safety concerns. Education funding is already being used at the local level to fund therapists, substance use counsellors, social workers, counsellors, lunch programs, and community programs within an education mandate and with insufficient funding (Lodge & Henderson, 2023). Thus, removing suspension as a last resort ought also to be paired with the introduction of other funded strategies and supports to use

instead of last-resort suspension. This could be done via a provincial MHSUD strategy for youth. **In sum, in order to meaningfully support school-based responses, schools need funding, staffing, and support to move away from historical models of MHSUD disciplinary responses, so they can facilitate non-punitive and tiered support models with fidelity.**

Coordination comparisons between jurisdictions. The Chief Public Health Officer of Canada has called upon stakeholders for MHSUD to "accelerate… collaborations between public health and social and economic sectors such as education, housing, and income support…. Public health and education leaders could enhance collaborative efforts to bolster healthy school communities (CPHO, 2022, p. 38). The comparison of Manitoba's MHSUD policy subsystem alongside BC's has been utilized in this study as a means to both compare coordination mechanisms in both jurisdictional sectors and to use exemplars from BC to inform evaluation of the Manitoba policy subsystem. As discussed in Chapter 4, BC was chosen as a comparator due to a longer implementation time with a Ministry of Mental Health and Addiction, and also by virtue of BC's trailblazing work with harm reduction responses to MHSUD, including framing MHSUD as a socio-ecological health issue.

As discussed earlier, BC has key coordinating actors (SSCCY, MMHA) and resultant policy actions (MMHA, 2018; SSCCY, 2016, SACY, 2023) which present as promising practices for coordination, by virtue of their use of comprehensiveness, aggregation and consistency in informing multi-sector policy plans (Hogl & Nordbeck, 2012). Very notably in this policy set of promising practices is the MMHA's strategic plan for MHSUD, *Planning for Hope* (2018), which not only includes stakeholders from MH, ME and MCFD, but which ensures that the strategic plans for MHSUD of those individual sectors aligns with the shared plan (MMHA, 2018; ME, 2022; MCFD, 2019; MH, 2018, 2022). Similar to the coordination

strategies employed in the Canadian Drugs and Substances Strategy, MMHA acts as an orchestrative actor by setting actionable goals with corresponding strategies and measurable outcomes to support including a public *Mental Health Strategy for Schools* (2020), a *Tripartite Partnership to Improve Mental Health and Wellness Services* (MH, 2020), and a *Child and Youth Mental Health Framework* (MCFD, 2019). In the BC model we see regional actors attempting to work in alignment with these broader provincial coordination structures, including local partnerships between healthcare authorities and school divisions (VSB, 2023b; VCHA, 2021). Nevertheless, the number of policy actions still results in some fragmentation and confusion in terms of service delivery (RCY, 2022).

In the Manitoban data set, we see a recent proliferation of symbolic policy documents centered in socio-ecological understandings of MHSUD which include references to stakeholders without their presence at the table (MMHCW, 2023; Virgo, 2018). Also press releases focused on pilot projects without a strategic plan to monitor fidelity for policy actions are present (MMHCW 2022b, 2022c, 2022d). Therefore, MMHCW's symbolic vision does not yet seem to operate in tandem with other stakeholders, who, as discussed above, are still mired in historic ministerial mandates. Put simply, the policy documentation associated with the MMHCW demonstrates a vision which does not operate in tandem with the vision of other stakeholders, or contain outcomes and measures to hold stakeholders accountable. Examples of this include the Virgo Report's emphasis on the importance of schools in a tiered service model, while only mentioning education as an anti-stigma partner in the form of primary prevention while ignoring their ongoing role in working with youth MHSUD (2018). Furthermore, MHSUD is not named directly as an independent policy problem in education documentation, which leaves school staff wondering where their role begins and ends, end up shouldering health care load (ME, 2022).

There is the lack of any overt mention of MHSUD in CFS documentation (MF, 2023b; 2022). Furthermore, the fact that Manitoba's *Pathway* document (2022) is devoid of material outcomes to support cross-sector strategies and instead relies on vague commitments to action including pledges to "work across sectors and levels of government" "support and enable all policy and government partners" (2022, p. 9), and to develop integrated models of care. That is, in the Manitoba policy subsystem we see a stated investment in socio-ecological models of health to inform cross-sector service provision. However, the actual values that are supported are ministry specific, specifically with a prioritizing of biomedical responses to MHSUD and single sector health application. Missing are also opportunities for all stakeholders to co-construct goals for youth MHSUD, plans which would include fidelity mechanisms, shared funding models, and shared visions. **In the BC data set we see coordinated strategies of material actions in service of symbolic declarations, whereas in Manitoba there is a paucity of coordination frameworks leading to limited impact on coordinated policy actions or policy integration models.**

Coordination with schools. In Chapter 2, the literature review included arguments for the enhancement and development of MHSUD services in schools through onsite programming and collaboration with primary care providers (Kutcher & McLucky, 2021). This literature review included discussions of primary prevention programs in schools which link health outcomes with service delivery model of the education system (Botvin & Griffin, 2007), multi-tiered systems of supports for MHSUD in schools including social and health care actors (Chafouleas et al., 2020), and mental health supports in schools via school-based health centers (Szumilas et a., 2010). Using this literature as a backdrop, in examining the types of MHSUD responses in school systems that emerged from the examined data set, we see some key differences between

jurisdictions. In Manitoba, MB/ME has utilized very few collaborative policy relationships (and, conversely, very few other ministries have employed collaborative policy relationships with MB/ME). One exception is MB/ME's *Planning for Safety and Belonging* (2018) document, which was rooted in collaborative work with the Joint Consortium for School Health (JCSH). The JCSH cites MHSUD heavily as a contributing factor to comprehensive school health, including addressing the importance of school climate for MHSUD support, preventative MHSUD programming, individual MHSUD needs assessments and referrals onto MHSUD specialists (JCSH, 2015). However, the *Planning for Safety and Belonging* document does not mention MHSUD directly, with the exception of listing it as an example of student need in a table. That is, this planning document, developed in connection with the JCSH, missed a key opportunity to spell out MHSUD support expectations for Manitoban schools. Similarly, *Standards for Appropriate Education* (MB/ME, 2022) was recently revised and missed another opportunity to lay out support plans for youth with MHSUD directly. Insofar as its mandate was to outline appropriate education programming for students, including working with outside service providers and sectors, MHSUD is not named directly. As noted earlier, at the regional level, we see other school divisions partnering with substance use services and therapeutic responses for MHSUD. Yet in the regional jurisdiction examined, these partnerships did not exist. **In Manitoba, an absence of policy integration provincially leads to inequities in local-level service options and service coordination mechanisms.**

Furthermore, the Public Schools Act dictates that schools program and support youth without waitlists, and the Standards for Appropriate Programming Regulation (2006) states that schools need to partner with outside service providers and outside sectors to support learning needs of youth. However, a paucity of coordination mandates, frameworks, and strategic plans at

the provincial and regional levels relegates this coordination work to schools and school staffs themselves. The Protection and Supporting Children (Information Sharing) Act (2017) allows schools to share information with health and social services actors in order to program effectively for students. However, in the *Standards for Appropriate Education* (2022) document, the mandate to schools is to reach out to other sectors in the best interests of youth, which places the locus of control within the school environment. As noted by the Virgo Report, presence of outside service provision in schools was dependent on each school's ability to fund it, and so was an inconsistent support (2018). Similarly, in terms of mental health service provision, the Virgo Report expressed concern with a lack of consistency in school sites abilities to support MHSUD literacy programming and a lack of coordination across the many contracted self-help/illness-focused organizations (Virgo, 2018). **In absence of actionable directives related to MHSUD regionally or provincially in Manitoba, existing policy mandates place the onus on schools to provide services without cross-sector coordination mechanisms in place to deliver appropriate cross-sector services.**

In the BC context, provincial collaboration mandates exist between MH, MMHA, and ME. MCFD also supports youth MHSUD service provision, but as noted earlier, it is not included as a prevalent actor in the MMHA strategic plan document, *Planning for Hope* (2018). At the regional level, the investments in collaboration at the provincial level led to education-health partnerships at the regional level, inclusive of preventative programming (VSB, 2023), tiered responses (BC/MMHA, 2022) and service provision from health care (VCHA, 2023), in line with the literature review references in the previous paragraph. **Policy integration pathways in BC at the provincial level are corelative with service coordination relationships at the regional level to provide multi-sector services to youth.**

Collaboration with Indigenous peoples and groups. Virani and Haines-Saah (2020) argued that positioning of MHSUD as a health issue must be paired with consideration of MHSUD as a social and equity issue. Across jurisdictions, there are symbolic calls to better collaborate, include, and understand Indigenous perspectives in order to plot policy pathways that incorporate Indigenous values (CPHO, 2018; PHAC, 2019b; MMHCW, 2022; MMHA, 2018; MCFD, 2015). However, the collaborative partnerships that exist to support this coordination hold key differences between the examined jurisdictions. In both jurisdictions, Indigenous authorities sit alongside non-Indigenous ministerial bodies, but in different capacities. In BC considerable work has gone into ensuring First Nations have autonomy in health care provincially (FNHA, 2023). In Manitoba, there has been advancements towards Indigenous autonomy in Child and Family Services agencies regionally (An Act Respecting Child and Family Services, 2022). That is, Indigenous actors are present in the ministerial landscape in both jurisdictions, though in different sectors and at different levels of influence. Furthermore, Horrill et al. (2018) noted that, "Lower levels of education are associated with poorer health… among Indigenous peoples in Canada; one underlying argument is that lower education results in a lack of awareness regarding early detection and preventative care, which is a barrier" to accessing healthcare (p. 4). Additionally, marginalized youth are at elevated risk for mental health difficulties as they encounter barriers to engagement with MHSUD services.

In the BC context, there are a number of Indigenous stakeholders that inform not only service-provision pathways, but also inform re-visioned ways to include Indigenous perspectives in ministerial models. For example, in *Centering First Nations' Concepts of Wellbeing* (BCAFN, 2020) there are calls for the government to consider "its own made-in-BC wellbeing index that considers Indigenous knowledge of environmental, health, education, community and cultural

outcomes in order to improve the livelihoods of all British Columbians" (p. 4). This framework developed by Indigenous stakeholders takes on understandings of wellness rooted narrowly in how policy actions affect the Gross Domestic Product (GDP). The FNHA partners with the Tripartite Committee of First Nations Health, The First Nations Health Council, First Nations Health Directors Association, and Indian Residential Schools Healing Program to challenge western models of human capital development as a governmental goal (FNHA, 2015). That is, there is a large amount of data documenting Indigenous voice in decision-making related to care and service provision. The Tripartite Committee of First Nations Health produced a Memorandum of Understanding (2018) documenting a shared commitment to place Indigenous perspectives and values prominently in programming models. More recently, the FNHA (2023) is tasked with a mandate of improved wellness for children, youth, and young adults, supporting Indigenous-led solutions, better substance use care and improved access to care.

In the Manitoban context, there is less of a focus on revisioning systems and frameworks to support Indigenous knowledges and perspectives, and more of a focus on service provision. For example, one of BCAFN's largest contributions to the policy subsystem of MHSUD is its work supporting access to Jordan's Principle as a funding body to access health, social, and education supports for youth. In terms of service provision, Indigenous leaders call on policy makers to treat the family as a unit and involve youth, elders, and the good of the broader communities where rather than thinking solely of self (MM7). In the Manitoban context, which is so focused on health care reform, the Manitoba AFN document is pigeonholed in advocating for access to services, rather than being able to engage in conversations about the types of services. This is the same type of diagnosis-treatment duality that we tend to see at the federal

level from ISC (2023) where the focus is ensuring Indigenous people can access MHSUD interventions, without great investigation into the modality of those interventions.

Earlier discussions on beliefs and interests have cited that policy learning has moved MHSUD from a justice to a health care to a cross-sector issue over the last decade or so. However, it may be that the BC jurisdiction is further along in embracing Indigenous narratives of care due to the existence of a First Nations Health Authority during a policy phase in which MHSUD care was situated in health. The Manitoban context has not had any implementation with Indigenous control over health or mental health. As shared earlier, though there is some Indigenous control of Child and Family Services agencies, current legislation does not directly list MHSUD as within the MF service mandate. Furthermore, Indigenous advocates argue that both the Virgo Report and MACY failed to adequately consult with Indigenous communities with regards to *how* to accomplish stated policy goals. This has arguably resulted in an overreliance on Jordan's Principle as a stated success story in supporting Indigenous MHSUD. **While government actors including WSD (2022) and MB/ME (2023) have both lauded the expansion of Jordan's Principle services in supporting Indigenous youth in Manitoba, this is in fact through provincial utilization of a federal funding pathway, and not the creation or investment in Indigenous-led or Indigenous-informed care provision frameworks.** Therefore, these policy pathways seem still entrenched in colonialist systems which accept and deny funding pathways rather than decolonizing MHSUD service provision systems.

In response to the research question, "How do the documented interests, beliefs, policy actions and coordination mechanisms compare between sectors, jurisdictions and levels of government?", the data set shows fragmented policy arenas both horizontally and vertically. While shared goals and coordination mechanisms at higher levels of governance were correlated

with better coordination regionally, coordination mechanisms existed only in pockets federally, and inconsistently between provinces, with Manitoba having very few coordination mechanisms comparatively. In the case of Manitoba, there is evidence of a continuum of care outside the health system being stunted, with over-reliance on intensive and involuntary reactions to MHSUD. School systems' overreliance on punitive responses to MHSUD require collaboration, funding, staffing and support to build the capacity in order to move past disciplinary responses for MHSUD. A lack of provincial coordination in Manitoba places the onus on schools to build partnerships, in comparison with the BC jurisdiction which has more provincial level partnerships.

Research Question 5: Comparisons and Recommendations for Policy Coordination to Support MHSUD in Schools.

Matson et al (2022) argued for "a paradigm shift away from a model based on diagnosis and pathology to one upstream, that of family-focused prevention and early intervention (p. 3). This includes adapting prevention and early interventions to primary care settings and removing barriers to care. Indeed, this vision of a response to MHSUD grounded in understandings of socio-ecological health has been shown to be shared by key advocates in the Canadian landscape, and key actors in provincial landscapes, including provincial ministries of mental health. This dissertation has employed a focus on policy coordination as both a goal and a strategy in the child-serving systems in the policy subsystem of MHSUD with the understanding that the inclusion of "first-order principles" (Hogl & Nordbeck, 2012), which support shared goals best support socio-ecological understandings of health (Peters, 2015).

ACF can be used to explicate belief and policy change when there is "goal disagreement" (Weible & Sabatier, 2014, p. 123). In the case of this study, uncovering the discourses of intent in policy documentation served as a mean into uncovering secondary beliefs of policy actors and policy actions. Across all examined stakeholder groups, the data showed that socio-ecological health responses to MHSUD are a dominant secondary belief related to MHSUD, following policy change via learning over the last couple of decades. However, my analysis shows that the emergence of this dominant symbolic secondary belief is often not supported by material policy actions in a system that has struggled to overcome ministerial isomorphism.

In response to the final research question of this thesis, What recommendations for policy coordination can be made to support MHSUD supports in schools? analysis is centered around key findings emerging from the conceptual approach and analytical framework undertaken in this study. From an MLG perspective, consideration of the confines that federalism places on the policy subsystem of MHSUD responses has been vital to consider who policy actors are in relation to each other. This serves to identify barriers to policy coordination in the federalist system and to investigate comparative legislative arrangements that exist in different jurisdictions. From an ACF perspective, illumination of the secondary beliefs and core beliefs inherent in documents has allowed for comparison and investigation into what existing policy frameworks are truly supporting (perhaps in contradistinction to what they have been purported to support). Both MLG and ACF, thus, provide pathways to understanding opportunities for and barriers to policy coordination in the policy subsystem of MHSUD.

In making recommendations, I turn to my primary research question—How can policy coordination be utilized to improve multi-sector support for youth with MHSUDs in Manitoba schools? —and provide seven key recommendations that have emerged from this analysis.

Chapter 7: Recommendations Emerging from the Policy Analysis

Recommendation 1: Align Federal Policy Direction with the Provincial Level

The federal policy advocacy for MHSUD spans across numerous federal actors (MHCC, CCSA, JCSH, HC, PSC, CPHOC, PHAC). Analysis of these stakeholder documents showed a plethora of policy advocacy aimed at regional and sub-regional actors (for example, CCSA, 2022; HC, 2022; JCSH, 2023; MHCC, 2016; PHAC 2021a; PHAC 2020b; PHAC 2021c). Advocacy includes calls to implement a variety of cross-sector supports for MHSUD, rooted in socio-ecological health such as community-connected, trauma-informed skill development (PHAC, 2021a); the embracing of socio-ecological models of health in community partnerships, food programs and harm reduction campaigns (PHAC, 2021b); increased collaboration with cross sector MHSUD service providers (PHAC, 2019c); and development of education resources for schools to utilize (CCSA, 2022). However, as demonstrated above, insofar as education is legislated provincially, calls to sub-regional actors without mandates or top-down imperatives by provincial ministries have inconsistent and limited reach. Furthermore, these recommendations are made without inclusion of provincial ministries so there are limited funds and resources deployed in support of such policy positions. Although the weight of research and advocacy at the federal level is unparalleled in the broader subsystem, the means of distribution for this research generation is misplaced. Work to align federal policy advocacy vertically to more directly impact legislative functions provincially to improve equity in provincial mandates through funding transfers has been shown as effective. However, shared interest in symbolic policy advocacy requires the presence of vertical stakeholders at a shared table of decision making. For example, this project has shown that by virtue of its voluntary mandate with

ministers of education, the Joint Consortium for School Health is under-utilized in supporting provincial mandates, despite the presence of provincial and federal stakeholders in this group. **In lieu of a system in which federal policy directives and recommendations are directed to provincial ministries—and not solely schools and school divisions who follow provincial directives—strengthening relationships between federal advocacy and provincial decision-making is necessary for better support of youth with MHSUD.** For example, this could take place through increased accountability mechanisms through the JCSH, Health Canada mandates (and funding) that formally take on mental health care in schools, and recommendations made to provincial stakeholders, rather than local level actors.

Recommendation 2: Utilize Coordinating Actor(s) with Accountability Mechanisms to Support Cross-Sector Policy Responses

In highly sectored systems, the inclusion of an actor (either independent or dependent) to facilitate coordination between sectors, including the development of accountability mechanisms, was shown in this thesis as a key factor in line with Dunst's (2006) argument regarding coordinator roles of service provision. The analysis showed that, SSCCY, the Canadian Drugs and Substances Strategy, JCSH, HCMO and MMHA were identified as key coordinating actors that prompted, coordinated and monitored policy coordination among other sectoral actors at the federal and provincial levels. As discussed in the previous section, these coordinating actors took on an authoritative role to support the emergence and regularization of cross-sectoral models in the federal and BC data set. HCMO, which was an exemplar from the Manitoban data set was discontinued in 2020.

Interestingly, MACY draws heavily on the Ontario model for coordination, which uses system navigators to support youth and families in accessing services at the service provision level in decentralized systems (MACY, 2020c). However, this does not serve to support systemic coordination and in fact serves to normalize fragmentation. The Manitoban policy subsystem for MHSUD is lacking in a coordinating actor to oversee, mandate, and hold accountable cross-sector responses to MHSUD in keeping with the evidence base for appropriate service provision. **Re-imagining the need for, and the positioning of, coordinating actors such as the HCMO and/or the MB/MMHCW as strategic planners is vital in work to provide cross-sector service provision with policy integration for MHSUD youth.**

Recommendation 3: Collect Data in the Manitoban Jurisdiction of Existing MHSUD Supports for Youth that Schools are Offering in Absence of Regional, Provincial, or Federal Directives.

The analysis of this study has documented that data informing next steps for MHSUD responses at the provincial level in Manitoba have not included stakeholders from education adequately at the data collection stage. For example, the Virgo Report has referenced the importance of education while only drawing financial education data as an evidence base (2018). The JCSH has informed the creation of a comparatively small and widely defined grant for healthy schools (Government of Manitoba, 2023), and MB/MMHCW's (2022) strategic planning document mentions schools as a prominent stakeholder without a voice at the table and in the absence of a proper plan for *youth* MHSUD (MACY, 2022). In the absence of directives for MHSUD in Manitoba schools—and indeed, in absence of a shared vision for youth MHSUD where there is a complete lack of support-based mention of MHSUD in MB/MF and MB/ME in

Manitoba—schools have still been tasked with meeting the needs of all youth on a daily basis. A different approach to data analysis is needed. Data on the types of supports, funds and resources in service of the supports schools are already utilizing to support youth with MHSUD should be gathered as an initial step. This data can inform initiatives to scale up, support more broadly, develop higher level coordination mechanisms in support of, and inform multi-sector policy alliances. **In the current context, evidence-based input from provincial, regional and local actors in education is necessary to better inform a cross-sector youth MHSUD strategy and service provision frameworks for MHSUD youth.**

Recommendation 4: Collect Data to Support Aligned Provincial-Level Directives for Cross-Sector MHSUD Care.

Provincial level mandates for MHSUD supports in schools and provincial level mandates for coordination to support cross-sector service provision are shown in the BC jurisdiction (BC/MMHA 2018, 2022). In the absence of such directives in the Manitoban context, subsidiary governments form their own partnerships, resulting in a lack of equity between jurisdictions. This project has shown that this fragmentation is contextualized in a system in which there is no agreement about MHSUD as a policy issue across jurisdictions and which isomorphic ministerial mandates trump common goals for MHSUD responses for youth. Thus, research to gather coordination mechanisms utilized in other provincial subsystems for MHSUD which support lower-level, cross-sector policy implementation could inform a robust strategy for provincial level coordination directives in Manitoba. **Though the federal government has collated a report on best practices for local level MHSUD service coordination (CCSA, 2015), additional data reporting on best practices of provincial level coordination nationally**

would be better tied to the actual federalist realities of legislation and service provision. Availability of recent and accurate data would help shape core beliefs and lead to policy learning, particularly if tied to funding supports for MHSUD initiatives. That is, policy coordination at the higher levels of governance could work to shift beliefs and interests through data, aligning policy learning and leading to more inherent policy change

Recommendation 5: Advance Multi-Sector MHSUD Supports for Youth in Schools

An over-reliance on last resort strategies was a common theme in the dataset where justice involvement, CFS involvement, and involuntary holds in both MB and BC context were cited as being utilized in absence of a robust continuum of supports. Just as this argument applied to community and health based MHSUD responses, so this same argument holds true in the context of schools. Analysis demonstrated an alignment across all sectors that MHSUD is a primary concern for school-aged youth in the current day. Yet, despite this, there is a paucity of directives and mandates for school systems in Manitoba as compared to the BC jurisdiction. In fact, in many cases, there is an outright lack of any reference to MHSUD in school documentation (MB/ME, 2018; MB/ME, 2022; WSD, 2023). In lieu of dedicated and coordinated frameworks that come with service delivery models—beyond disciplinary ones, which are well entrenched—funding for MHSUD initiatives, relevant staffing, professional development mandates, triage mechanisms. and coordination relationships are left to school staff. Schools themselves are left to both implement existing education mandates, and to develop their own mechanisms to support youth who struggle with MHSUD, which has resulted in scattered supports. Given Wietkorowicz's (2010) argument that in large urban and large rural jurisdictions alliance models are reliant on external governance and mandates, in absence of these external

mandates, regional actors are met with a lack of infrastructure to support effective and evidence-based cross-sector service delivery models. **Mandates to support school-based frameworks that deal directly with MHSUD and map out school-based cross-sectoral response models to support school staff in supporting students must be developed to support MHSUD youth in Manitoba.** I would argue that given the data collected here, and given the cross-sector nature of the work to be undertaken in schools, coordinating actors (provincial corss-sector ministries, offices like MB/HCMO or BC/SSCCY) are best positioned to take on this work.

Recommendation 6: Coordinate Universal and Targeted Supports in Manitoba Schools

When comparing the Manitoban data set, there are identified gaps for school-based service provision, partially because the onus is on school staff to be all things to all people in absence of the types of cross-sector supports we see for MHSUD in the BC model (BC/MCFD, 2020; BC/MMHA, 2022; VHCA, 2023). At the universal tier in Manitoba, schools are legislated to provide basic MHSUD education via the health curriculum. However, comparison with the Vancouver jurisdiction exemplifies the ways in which collaborative relationships with other sectors can be utilized to expand this educative and preventative work (VSB, 2023). At the intensive tier, an over-reliance on involuntary holds and calls to expand residential treatment reside outside the education sector (MACY, 2020c). However, at the targeted level, there is a substantial lack of guidance, coordination relationships, staffing and expertise to support youth with worsening mental health both to access effective supports, and with being successful in the school day. In the MB jurisdiction, provincial directives for MHSUD supports in schools are jumbled together with support services for youth with additional needs. By comparison, in BC, provincial partnerships with BC/MH, BC/MMHA and BC/MCFD partner schools with experts in

MHSUD care. This comparison deomnstrates a lack of provincial support for tiered programming in Manitoba. Furthermore, at the regional level, though some school divisions in MB employ trauma counsellors and substance use counsellors, such supports are inconsistently implemented in absence of any directives or financial support for these interventions. Again, if we compare this with the Vancouver jurisdiction in which partnerships between school boards and health authorities support triage mechanisms, supports in schools, and supports for families, we can see the ways in which a lack of tiered interventions in Manitoba is entrenched in this highly sectoral system. Given a concerning lack of availability of robust universal supports in schools and a lack of virtually any provincially driven targeted supports for youth MHSUD in schools, school budgets and school staffs struggle to support these initiatives. **A tiered framework—ideally co-constructed by ministries of health, social services, education, and mental health—to support cross-sectoral universal and targeted MHSUD in schools is vital to meet the needs of MHSUD youth and their families.**

Recommendation 7: Increase Involvement of Indigenous Stakeholders to Plan for MHSUD Support as a Reconciliation Issue.

In comparing the Manitoba jurisdiction with the federal policy subsystem for MHSUD and the provincial policy subsystem for MHSUD, key themes emerged in regards to presence of Indigenous voice. At the federal level, Indigenous Services Canada was shown to be stuck in a biomedical model of diagnosis and treatment for MHSUD where there was a reliance on service provision, rather than a fulsome positioning of responses in iterations of socio-ecological health. In BC, by comparison, the number of Indigenous stakeholders informing MHSUD responses from a socio-ecological health perspective are legion (for example, FNHA, First Nations Health

Council, and First Nations Health Directors). In the Manitoban jurisdiction, Indigenous-led governance of Child and Family Services agencies has not translated to any similar governance mandate in the health care system and only identified provincial level Indigenous stakeholder is Manitoba AFN. Furthermore, Manitoba does not have anything like BC's Tripartite Committee of First Nations Health's Memorandum of Understanding documenting a shared commitment to place Indigenous perspectives and values prominently in health and mental health programming models (FNHA, 2018), save for northern Manitoba Indigenous communities (MM7). Nor does Manitoba have any MB/MF or CFS mandate for MHSUD in child welfare mandates provincially (though partnership between SCO and MacDonald Youth Services does show that regional governing actors are taking this work on). Thus, at the provincial level the only place we see Indigenous-led stakeholders given room to enter discussions about MHSUD are in policy mandates and support documents for Jordan's Principle (AFN, 2022). While at the surface level, expanded advocacy for the use of Jordan's Principle funding by MB/MF, AFN, SCO, and WSD may appear as progressive utilization of Indigenous perspectives, we must also recall that critics have argued that it represents a "projectified" approach to policy, and therefore is, in itself, a silencing of broader approaches to policy equity (Sinha et a., 2021). Because Jordan's Principle is a funding mechanism and not a pathway for collaboration or inclusion of Indigenous perspectives in the policy subsystem for MHSUD, it does serve as a silencing of more robust conversations about Indigenous-led and Indigenous knowledge-inclusive service provision. It is noteworthy that in the BC jurisdiction where more robust collaboration with Indigenous governance structures is documented, there is far less reliance on discussions of Jordan's Principle. **Given this context, it is vital that there is an increased investment by governmental actors in relationships and knowledge generation with Indigenous**

communities to inform how Indigenous paradigms of wellness can guide not just funding pathways, but lead to holistic multi-tiered systems of support for Indigenous MHSUD youth in schools.

Conclusion

There is general consensus nationally that youth MHSUD is at a crisis point, with over 1.6 million youth across Canada needing MHSUD services, and often waiting more than two years for treatment (Lamoreux, 2023). The post-covid context that we find ourselves in has health care services scrambling to support youth with MHSUD all while advocates decry the lack of responsive systems to support youth (MACY, 2022; RCY, 2022). These additional pressures on resources exist at the same time as growing agreement in the media (MM1), advocates (MACY, 2018), and symbolic policy directives (MB/MMHCW, 2022) that substance use issues ought to be dealt with as a socio-ecological health issue, rather than in single sector responses of biomedical health or safety/justice paradigms. At the same time, youth are in schools daily and schools have existing structures to implement education, prevention, and triage systems in a multi-tiered system of support. Therefore, in terms of policy learning and the ability for policy systems to respond to new realities, our current context may provide an opportunity to bifurcate from path-dependent models of policy segregation related to MHSUD, particularly with regards to schools' positionality in sectored federalism. Insofar as Braun (2008) argued, "moral obligation seems… to be a sine qua non for achieving encompassing political coordination concerning the knowledge space" (p. 292). Shifting realities and perspectives on MHSUD may provide an opportunity to reframe policy goals and policy directives with a focus on policy coordination.

This research has explored the multi-level and densely sectored policy subsystem of MHSUD in Manitoba and British Columbia as a means to answer the primary research question, How can policy coordination be utilized to improve multi-sector support for youth with MHSUDs in Manitoban schools? This research has found that shifting perspectives from treating

MHSUD as a punitive issue, to a safety issue, to a biomedical issue, to a socio-ecological issue has not been matched with policy actions in support of evolving policy interests. In particular in Manitoba, this project has found that youth MHSUD policy in general is mired in bio-medical discourses, discussions of health care reform, and discourses of safety. Furthermore, though symbolic policy declarations have embraced cross-sector and socio-ecological health paradigms, these policy learnings are far under-represented in material policy actions.

By comparing the Manitoban policy system with that of BC, promising practices for material policy coordination and integration have been identified. In particular, the project finds that federal, provincial, and regional policy directives are not aligned and, thus, an organized system of vertical and horizontal cross-sector policy coordination to support MHSUD is vital across Canada, but in Manitoba in particular. In addition, the research has found that cross-sector coordination actors and coordination strategies are poorly utilized in Manitoba, resulting in inconsistent supports for MHSUD, particularly in schools. A review of coordination strategies and coordination bodies in other jurisdictions is timely as well. Furthermore, despite provincial data collection on MHSUD systems in Manitoba, no data has been gathered on school-based reponses to support MHSUD across school divisions. In lieu of effective coordination strategies and cross-sector coalitions to support socio-ecological health models of MHSUD, regional and local actors are left to take up the work of service coordination. Thus, additional data to understand the fulsome picture of what schools are doing in lieu of provincial direction is vital to understand the work currently being done and the work yet to do.

Furthermore, this research has demonstrated that the siloed nature of Manitoban MHSUD service provision has resulted in an over-reliance on last-resort policies and a lack of robust universal and targeted supports for youth with MHSUD across sectors. Increased coordination

strategies and coordinator actors across sectors in the jurisdiction of BC was seen to be correlated with an increased in tiered interventions and an increase of access points. In fact, this is consistent with with the global strategy long advocated by the World Health Organization, namely to build and blend mental health expertise within primary care platforms, including integration of mental health, physical health, alcohol and other drug, and vocational support (McGorry et al., 2019).

Finally, this project has identified that, in Manitoba, there is a conflation of discussions of Indigenous-led strategies for MHSUD with discussions of funding provision. That is, despite symbolic commitments to decolonized MHSUD care in Manitoba, the provincial and federal policy landscapes continue the hegemonic hold of colonialist control. BC provides exemplars of Indigenous-led solutions which are not tied only to western paradigms of diagnosis and treatment and which extend ideations of wellness beyond human capital development.

This project contributes to theoretical perspectives as it utilizes MLG as a conceptual lens and ACF as an analytical framework to conduct a Stakeholder Analysis to uncover the policy interests, beliefs, actions, and existing coalitions that currently exist in hegemonic positions and to identify shifts in policy as a result of policy learning. This methodology using MLG alongside ACF contributes to the analytical research base in presenting a methodology that digs both into the constellation of relationships inherent in contemporary policymaking and into the spoken and unspoken policy interests and beliefs that are ingrained in these relationbships.

If we return to the vignette of “Hannah” explored in the Introduction of this project, we can imagine how coordinated and cross-sector supports for MHSUD might have impacted Hannah’s care. If policies included coordinated responses between health, social services and schools, she might have been able to be referred on from the school context itself rather than

needing to juggle multiple access points, system mandates and waitlists. School-based social work and mental health workers from the school system could have had voice in other policy sectors to advocate for social and health care without requiring duplication of disclosures and referral processes across health and social service sectors. Health care teams in schools could have been able to meet Hannah and her grandmother where they already were, rather than making them jump through multiple hoops in separate geographical areas for care. Indigenous perspectives could have been infused into responses to welcome Hannah into care from the safety of her school environment rather than alienating her through multiple triage points and waiting rooms. A continuum of supports initiated by the school team, in consultation with social and health care sectors could have replaced reactive and emergent models of care.

From a MLG perspective, in Canada's federalist context, large-scale policy change may often be difficult given the large number of policy actors and horizontal and vertical governance structures (Vergari, 2018). However, in the midst of this behemoth of a system, school staff are daily in the position of needing to support youth with languishing mental health and substance use issues without appropriate cross-sector funding, cross-sector cooperation mandates, or tiered responses systems. Given this backdrop, this project highlights the need for the education system to be situated in a center of a system of cross-sector MHSUD policy mandates rooted in ideations of socio-ecological health, which are coordinated and aligned.

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