



ACCESS TO CHILD AND YOUTH MENTAL HEALTH SERVICES IN BC

Barriers, recommendations, and strategies
for improvement

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EXECUTIVE SUMMARY

This report summarizes a literature review for the Ministry for Children and Family Development (MCFD) focusing on strategies for improving access to Child and Youth Mental Health (CYMH) services, supports, and treatment. Research consisted of a review of publicly available academic, grey, and policy literature produced since 2011, in order to answer two research questions:

- 1) What are the barriers to accessing CYMH services in BC, and what steps have been taken to overcome them?
 - a. What are the system-level barriers to accessing CYMH services in BC?
 - b. What strategies have been recommended to address these barriers?
 - c. How have these strategies been implemented?
- 2) Where barriers remain, what strategies can be used to address them?

The literature review is organized into two sections. The first is a review of reported system-level barriers, recommendations, and actions related to improving access to CYMH services in the BC context. The second is a scoping review of academic and grey literature describing and assessing evidence for various strategies for improving access to CYMH services. Access improvement strategies can be divided into service management strategies including waitlist management, increasing engagement, centralized intake, and collaborative care; and service delivery strategies including brief therapy, technology-based delivery methods, and emerging delivery models. Additionally, there is a brief discussion of literature regarding the implementation of two child and youth mental health service transformation models, the Choice and Partnership Approach (CAPA) and Australia's National Youth Mental Health Foundation, also known as headspace. An appendix consisting of an annotated bibliography of access improvement literature is included.

Results of the literature review indicate that barriers to accessing mental health services for children, youth, and families are identified in reviews such as those commissioned by Government (e.g., Berland, 2008), by oversight bodies (e.g., Representative for Children and Youth, 2013), and by parliamentary committees (e.g., Select Standing Committee on Children and Youth, 2016). System-level barriers to CYMH services in BC include long wait times, a fragmented system that is difficult to navigate, and services that are inadequate, inappropriate, or nonexistent in some areas. Consistent with Government's strategic plans (e.g., Ministry of Health Services, & Ministry of Children and Family Development, 2010), MCFD has taken steps to improve access to CYMH services, including opening walk-in intake clinics, developing an online inventory and map of services, supporting direct system navigation and peer support, expanding the use of videoconferencing services, and developing Youth to Adult Mental Health

Transition Protocols. These initiatives align with many of the formal recommendations from the Select Standing Committee on Children and Youth and the Representative for Children and Youth.

Research in child and youth mental health services is not well developed, and while there are many strategies in use, few have been shown to be effective in improving access. The approaches that show the most promise include collaborative care, centralized intake, brief therapy, peer support, some computerized CBT programs, and offering tele-mental health via telephone or videoconferencing. The CAPA service transformation model has demonstrated success in reducing wait times, and the headspace model has improved access for many groups of young people, but not all. Many of the strategies identified in the literature as having the potential to positively impact access to child and youth mental health services have been more extensively researched in the context of primary care and/or adult mental health care; additional research into the efficacy of their application in child and youth mental health contexts is needed before the evidence base will be strong enough to inform policy decisions.

INTRODUCTION: THE IMPORTANCE OF MENTAL HEALTH CARE FOR CHILDREN AND YOUTH IN BC

Access to mental health care is important for children and youth experiencing mental health concerns (Berland, 2008; MCFD Child and Youth Mental Health Policy, 2009; The Canadian Association of Paediatric Health Centres, The National Infant Child and Youth Mental Health Consortium Advisory, & The Provincial Centre of Excellence for Child and Youth Mental Health at Children's Hospital of Eastern Ontario, 2010). The BC Government has stated that improving access to timely and effective Child and Youth Mental Health interventions and supports is a priority (Ministry of Children and Family Development, 2015; Ministry of Health Services & Ministry of Children and Family Development, 2010). This project investigates strategies for improving access to publicly available community-based child and youth mental health (CYMH) treatment, services, and supports provided by the Ministry of Children and Family Development (MCFD) across British Columbia. It is meant to build on and expand previous work done by the Ministry in this area (MCFD Child and Youth Mental Health Policy, 2009, 2012).

High-quality epidemiologic surveys from the US, the UK, Puerto Rico, Israel, and Hong Kong have led researchers at the Children's Health Policy Centre at Simon Fraser University to estimate that approximately 12.6%, or 84,000, BC children and youth experience clinically significant mental health disorders (Waddell, Shepherd, Schwartz, & Barican, 2014); however, we do not have definitive data on the current prevalence of mental disorders and mental health problems affecting children and youth in our province (Representative for Children and Youth, 2013; The Canadian Association of Paediatric Health Centres et al., 2010). According to the most recent BC Adolescent Health Survey (A. Smith et al., 2014), about one fifth of students in grades 6 through 12 rate their mental health as poor or fair, as opposed to good or excellent. This is similar to the estimated rate of mental disorders and mental health problems in the general population in Canada (Canadian Mental Health Association, 2016a; Ministry of Health Services & Ministry of Children and Family Development, 2010; The Canadian Association of Paediatric Health Centres et al., 2010). Research has shown that approximately 75 percent of adults with mental health and substance use clinical diagnoses experienced the onset of symptoms during childhood or adolescence (Kessler et al., 2005; Kim-Cohen et al., 2003); in fact, Kim-Cohen et al. (2003) recommend reframing most adult mental health disorders as extensions of juvenile disorders. A 10-year longitudinal study found that although most adolescent mental health disorders were no longer present in adulthood, people who had experienced anxiety and/or depressive disorders during adolescence were two to three times more likely than their peers to experience anxiety and/or depressive disorders in adulthood (Pine, Cohen, Gurley, Brook, & Ma, 1998). Treatment for mental disorders and mental health problems during childhood and adolescence may decrease chronic mental health disability in adulthood (Kim-Cohen et al., 2003; Ministry of Health Services & Ministry of Children and Family Development, 2010; Roza, Hofstra, Van Der Ende, & Verhulst, 2003; The Canadian Association of Paediatric Health Centres et al., 2010). Timely and effective mental health care may also play a role in promoting healthy development and supporting children and youth's ability to function at home, at school, and in the community (Berland,

2008; The Canadian Association of Paediatric Health Centres et al., 2010; The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001).

This research project examines the documented system-level barriers to accessing CYMH services in BC, such as long wait times, fragmentation of services, gaps in services, and lack of youth-friendliness, and outlines the recommendations made by other government bodies based on input from stakeholders concerning these barriers, and steps that have been taken to implement these recommendations. Further, this project investigates evidence-based system-level strategies that may be used to improve access to existing community-based CYMH services and supports in BC, including service management strategies, service transformation models, and service delivery strategies.

Much of what is discussed in this report is based on key terms that are used throughout. These, and a more detailed definition of access, are provided below.

KEY TERMS

MENTAL HEALTH: The World Health Organization (WHO) defines mental health as “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community” (World Health Organization, 2014). Some people would call this *good* mental health, or mental wellness, explaining that mental health exists on a continuum from good to poor, just as physical health does (Keyes, 2002; S. Smith & Saari, 2013).

MENTAL ILLNESS/MENTAL DISORDER: In Western societies, these terms generally refer to clinically diagnosed mental conditions that alter the way a person thinks, feels, or behaves, and are associated with significant distress and impaired functioning (Canadian Mental Health Association, 2016b; Government of Canada, 2015; Mind, 2013). Keyes (2002) posits that while mental illness and mental health are related, they are independent of each other: it is possible that a person can have poor mental health without mental illness, and good mental health with mental illness (S. Smith & Saari, 2013).

MENTAL HEALTH PROBLEM: This term can refer to a mental illness or disorder, or to mental, behavioural, or emotional difficulties that may be early signs or symptoms of disorders but are not frequent or severe enough to meet criteria for diagnosis (Mind, 2013; The Canadian Association of Paediatric Health Centres et al., 2010). It can also simply mean poor mental health, independent of mental illness (such as experiencing a sense of loneliness, emptiness, or lack of vitality; Smith & Saari, 2013). In this report, it is used to denote poor mental health or sub-clinical conditions.

EVIDENCE-BASED: The term evidence-based implies that a treatment, practice, or strategy is backed by high-quality, robust and valid scientific evidence (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald,

2001). It is often used loosely, however: Hoagwood et al. (2001) point out that, in the field of child and adolescent mental health, much of what is called research on evidence-based practice is more accurately described as clinical treatment efficacy research. There are four criteria that can be used to assess an evidence base: a theory that relates a hypothetical mechanism to a clinical problem; basic research that assesses the validity of the mechanism; preliminary outcome evidence that shows that application of the mechanism changes the relevant outcomes; and process-outcome connections, which demonstrate the relationships between process change and clinical outcomes (Hoagwood et al., 2001; Kazdin, 1999).

DEFINING ACCESS: AVAILABILITY, AFFORDABILITY, AND ACCEPTABILITY

Access to healthcare is a complex and multidimensional concept that is not often clearly defined in the literature (Boyle, Appleby, & Harrison, 2010; McIntyre, Thiede, & Birch, 2009; Penchansky & Thomas, 1981). The degree of fit between a healthcare system and the individuals it serves is central to the concept of access: it is a dynamic process, involving communicative interaction between individuals and the system (Donabedian, 1972; McIntyre et al., 2009; Penchansky & Thomas, 1981). McIntyre, Thiede, & Birch (2009) argue that access is most completely described by the domains of *availability*, *affordability*, and *acceptability*, and that when all three of these components are in place, the result is that people are empowered to use services when needed.

Availability, or physical access, describes the relationship between the volume and type of services offered and the volume and type of clients' needs: whether the appropriate providers and services are supplied in the right place at the right time (McIntyre et al., 2009; Penchansky & Thomas, 1981). Availability includes factors such as whether the physical locations of healthcare facilities are accessible to those who need them; whether the hours of service and use of appointment systems fit with the times that individuals need services to be provided; and whether the type, range, quantity, and quality of services provided match the nature, extent, and severity of the needs of individuals (McIntyre et al., 2009).

Affordability, or financial access, refers to the degree of fit between costs of using the service and the individual's ability to pay. Full costs to the individual include the price of service at the point of delivery, which may be influenced by the level of public funding; costs associated with transportation, child care costs, etc.; and indirect costs such as lost income or productivity while traveling to and from the provider and waiting to be seen (McIntyre et al., 2009). Affordability can also refer to the "opportunity cost" of using services, which is context-dependent (McIntyre et al., 2009). An example this would be when a woman uses a service provided by male service providers in countries where at least part of the population believes this to be inappropriate: this would result in a significant opportunity cost for the woman in terms of self-esteem, personal standing, and community acceptability (McIntyre et al., 2009).

Acceptability, or sociocultural access, is one of the least-studied aspects of access (McIntyre et al., 2009). It concerns the relationship between clients' attitudes about and expectations of personal and practice characteristics of providers and actual characteristics of existing providers, as well as providers' attitudes and expectations regarding patients (McIntyre et al., 2009; Panchansky & Thomas, 1981). These characteristics include attributes such as age, gender, or ethnicity of the provider or of the patient, and type, location and religious affiliation of the facility. These attitudes influence the individual's ability to receive care (McIntyre et al., 2009). Provider and patient expectations about respect for individuals, as well as respect for traditional or alternative beliefs about healing systems, also influence acceptability of services (McIntyre et al., 2009).

Equity is a fundamental concept in evaluating access (Gulliford et al., 2002). Equity can be thought of as existing in two dimensions: horizontal equity means that all groups with equivalent needs have the same access to services; vertical equity means that groups with different needs have access to services that match those needs – services are appropriate in terms of volume, content, and quality (Gulliford et al., 2002). Horizontal equity is fairly easy to measure (are the same services provided to all groups?); vertical equity can be much more difficult to measure (is each group receiving the services it needs?) (Gulliford et al., 2002).

BC AND MCFD STRATEGIC PLANS IN CYMH ACCESS

The provincial government and MCFD have strategic plans in place that reflect their priorities in the provision of CYMH services. Strategic planning for mental health and substance use services in BC is guided by *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (Healthy Minds, Healthy People)*, launched in 2010, and by the recently released *B.C.'s Mental Health and Substance Use Strategy: 2017-2020*. *Healthy Minds, Healthy People* employs a "whole systems" approach, which is described as recognizing "the importance of involving all partners when making decisions for planning, developing, and implementing" services, and especially involving people who use services (Ministry of Health Services & Ministry of Children and Family Development, 2010, p.10). *Healthy Minds, Healthy People* outlines a population-based framework that focuses on the mental health needs of groups rather than individuals, and places a strong emphasis on the mental health needs of children (Ministry of Health Services & Ministry of Children and Family Development, 2010). One of the three stated aims of the plan is to "improve the quality and accessibility of services for people with mental health and substance use problems" (Ministry of Health Services & Ministry of Children and Family Development, 2010, p. 8). MCFD's 2015/16-2017/18 Service Plan lists "improve consistency and accessibility of CYMH services" as one of its objectives (Ministry of Children and Family Development, 2015, p. 9). Three strategies for achieving this objective are listed:

- Evaluate the CYMH Intake Clinic model and expand to remaining CYMH intake locations in BC (CYMH walk-in intake clinics are designed to streamline the intake process and decrease the wait time between referral and assessment)
- Define mandate and services for CYMH community based teams
- Expand the use of tele-mental health (tele-psychiatry via videoconferencing and telephone) to improve access to a variety of services and supports, particularly in rural and remote communities (Ministry of Children and Family Development, 2015, p. 9).

In previous work on this topic, MCFD identified evidence-based approaches to improving access to CYMH treatment, services, and supports, including tele-mental health care, web-based education and support, school-based care, primary care, collaborative care, and family-centered care (MCFD Child and Youth Mental Health Policy, 2012; Ministry of Health Services & Ministry of Children and Family Development, 2010).

RESEARCH QUESTIONS

- 1) What are the barriers to accessing CYMH services in BC, and what steps have been taken to overcome them?
 - a. What are the system-level barriers to accessing CYMH services in BC?
 - b. What strategies have been recommended to address these barriers?
 - c. How have these strategies been implemented?
- 2) Where barriers remain, what strategies can be used to address them?

RESEARCH PROCEDURE

Answers to these research questions were sought through conducting a scoping review of existing publicly available academic, grey, and policy literature produced since 2011, which was the date of MCFD's last literature review of this topic. The review focused primarily on comprehensive coverage (breadth) of available literature (Arksey & O'Malley, 2005). Literature was found using Internet search engines as well as online databases including CINAHL, Cochrane Database of Systematic Reviews, ERIC, MEDLINE, PsycINFO, and Social Work Abstracts. Primary search terms included *infant, child(ren), youth, adolescent, mental health (care, programs, services, service delivery system, promotion, prevention, support, treatment) and access*.

The term scoping review is usually used to refer to a review that prioritizes breadth over depth. Arksey and O'Malley (2005) identify four common uses for a scoping review:

- To examine the extent, range, and nature of research activity in a particular area
- To determine the value of undertaking a full systematic review
- To summarize and disseminate research findings to policy makers, practitioners, and consumers
- To identify research gaps in the existing literature

The main purpose of the scoping review involved in this project is to summarize and disseminate research findings to policy makers and practitioners within MCFD. It also identifies gaps in the literature.

Unlike systematic reviews, which are usually guided by a highly focused research question, scoping reviews involve identifying all relevant literature, regardless of study design or source (Arksey & O'Malley, 2005). For this project, this meant searching grey literature, policy literature, and other government publications and reports as well as peer-reviewed academic literature for any information relevant to the research questions. The process of identifying relevant literature was not linear but iterative, requiring the researcher to engage with each stage reflexively, and repeat steps when necessary, to ensure that the literature was covered comprehensively (Arksey & O'Malley, 2005).

There is some disagreement in the literature over whether a scoping review should evaluate the quality of primary studies: some authors state that scoping reviews do not involve quality assessment of primary studies (Arksey & O'Malley, 2005; Davis, Drey, & Gould, 2009; Levac, Colquhoun, & O'Brien, 2010), while others recommend that they should use some form of quality assessment, especially if they are aiming to identify gaps in the literature (Daudt, van Mossel, & Scott, 2013; Dijkers, 2011). Dijkers (2011) argues that undertaking a scoping review in order to map the research in a particular area and identify gaps may be essentially useless if the quality of the existing studies is not assessed: there may be a substantial number of studies in a particular area of interest, but if they are all of poor quality, they will have limited usefulness in synthesizing knowledge and making recommendations. Therefore, this review provides some discussion of the quality of academic studies identified in order to clearly illustrate where gaps may exist.

The focus of this scoping review is on finding and examining system-level approaches to improving access to community-based child and youth mental health treatment, services, and supports. It is not concerned with residential CYMH treatment services, and does not explicitly focus on improving access at the individual and community levels, though in some cases system-level access improvement is linked to individual- and community-level access improvement. It focuses on mental health services for children and youth, including services that address mental health and substance use together.

RESEARCH RESULTS

QUESTION 1.A.: WHAT ARE THE SYSTEM-LEVEL BARRIERS TO ACCESSING CYMH SERVICES IN BC?

There are many important factors that negatively influence the ability of children, youth, and families to seek help for mental health and substance use problems. Barriers to healthcare access generally, and access to CYMH services, treatment, and supports more specifically, are well documented in the literature (The Canadian Association of Paediatric Health Centres et al., 2010). These barriers can be described as existing in each of the domains of availability, affordability, and acceptability (McIntyre et al., 2009) at the individual, community, and system levels. Some commonly cited individual- and community-level barriers encountered in BC are: stigma, discrimination, and concerns about confidentiality (Cox, Smith, Peled, & McCreary Centre Society, 2013; Ministry of Health, 2012; Ministry of Health Services & Ministry of Children and Family Development, 2010); lack of trust of adults or professionals (Cox, Smith, Peled, et al., 2013; Donaldson et al., 2016; Ministry of Health, 2012); general lack of understanding about mental health and available services (Cox, Smith, Peled, et al., 2013; Donaldson et al., 2016; Ministry of Health, 2012; Representative for Children and Youth, 2013); mental health status and comorbidity (Cox, Smith, Peled, et al., 2013); services located in inconvenient places or unsafe neighborhoods (Cox, Smith, Peled, et al., 2013; Donaldson et al., 2016); social location of clients (some groups are more comfortable seeking help than others; Cox, Smith, Peled, et al., 2013; The Canadian Association of Paediatric Health Centres et al., 2010).

In addition to individual- and community-level barriers, a number of system-level barriers to access have been identified in BC. One of the most frequently cited is long wait times for services, sometimes more than a year, especially in smaller communities and Indigenous communities (Canadian Mental Health Association, 2014; Donaldson et al., 2016; Representative for Children and Youth, 2013; Tourand, Smith, Poon, Saewyc, & McCreary Centre Society, 2016). Long wait times for mental health services can contribute to a deterioration of mental health and ability to function in daily life, and reduce motivation to seek help (Cox, Smith, Peled, et al., 2013; Representative for Children and Youth, 2013); in a McCreary Centre Society study of youth who had experience with mental health services, 35% indicated that they had not accessed services they felt they needed because of being placed on a waiting list (Cox, Smith, Poon, Peled, & McCreary Centre Society, 2013).

Adding to the frustration of long wait times is a fragmented system of mental health care that many families find confusing to navigate (Representative for Children and Youth, 2013). In BC, publicly funded community-based mental health services for children and youth are delivered by MCFD, health authorities, contracted service providers, paediatricians, and psychiatrists in private practice. MCFD is responsible for developing policies and setting standards for the delivery of community-based mental health services for children and youth; however, there is no single set of core services that is delivered consistently in every area of the province (Representative for Children and Youth, 2013). CYMH policies and standards are interpreted and implemented independently in each of MCFD's 13 geographical service delivery areas, resulting in a variety of delivery methods and management structures across the province (Representative for Children and Youth, 2013). For example, in most areas, CYMH services are delivered by teams of mental health practitioners employed by MCFD, but in some places they are provided by

practitioners working for contracted agencies, or by individual professionals contracted by MCFD (Representative for Children and Youth, 2013). A 2013 report prepared by the Representative for Children and Youth (RCY) entitled *Still waiting: First hand experiences with youth mental health services in BC* described a “fractured youth mental health system that is confusing and frustrating for youth and their families to navigate” (Representative for Children and Youth, 2013). The lack of integration between services can lead families to assume that “every door is the wrong door” (Mathias et al., 2015). A lack of information sharing between ER doctors, family doctors, and CYMH practitioners disrupts continuity of care and may result in retraumatizing youth who have to tell their story multiple times (Canadian Mental Health Association, 2014; Representative for Children and Youth, 2013), and a lack of information sharing with families (sometimes due to actual or perceived legal barriers) can prevent families from being adequately involved (Canadian Mental Health Association, 2014; Donaldson et al., 2016; Representative for Children and Youth, 2013). Further, when youth who are receiving mental health care transition to the adult mental health system, there are gaps in communication and available services that sometimes result in youth failing to receive services after their 19th birthday (Canadian Mental Health Association, 2014; Ministry of Health, 2012; Representative for Children and Youth, 2013).

In some rural, remote, and Indigenous communities, there are not enough CYMH services offered, no culturally appropriate services offered, or no services offered at all; this leaves children, youth, and families with a choice between leaving their support networks to access help elsewhere, or trying to manage their symptoms on their own (Cox, Smith, Poon, et al., 2013; Donaldson et al., 2016; Tourand et al., 2016).

When they do access CYMH services, many youth and their families have found that they are not youth or family friendly, which adds to the stigma associated with seeking mental health care, and discourages many youth from pursuing treatment (Cox, Smith, Poon, et al., 2013; Donaldson et al., 2016; Mathias et al., 2015; Representative for Children and Youth, 2013). According to the BC Integrated Youth Services Initiative (BC-IYSI) working group, many existing mental health centres can best be described as “colourless, rule-bound and demoralizing” (Mathias et al., 2015, p. 7).

Barriers to CYMH services may be higher for some groups in BC, including Indigenous children and youth, children and youth in care, LGBT youth, youth with unstable or inadequate housing, transition-aged youth, immigrant and refugee children and youth, children and youth whose parents experience mental health and/or substance use problems, children and youth who have experienced sexual abuse, children and youth with dual diagnoses or concurrent disorders, children and youth living with a disability or chronic health conditions, and children and youth with specific mental health issues such as eating disorders and ADHD (Berland, 2008; Canadian Mental Health Association, 2014; Donaldson et al., 2016; MCFD Child and Youth Mental Health Policy, 2009). Fewer than half of children and youth who need mental health care receive it, with some estimates as low as 20 percent (Canadian Mental Health Association, 2016a; Representative for Children and Youth, 2013; The Canadian Association of Paediatric

Health Centres et al., 2010). This is evidence that a significant amount of work remains to be done in order to make CYMH services accessible and equitable for all of BC's children and youth.

QUESTION 1.B.: WHAT STRATEGIES HAVE BEEN RECOMMENDED TO ADDRESS THESE BARRIERS?

Healthy Minds, Healthy People and MCFD strategic plans identify key strategies for improving access to services. In addition, since 2011, a number of formal recommendations have been made concerning barriers to CYMH services in BC. The Select Standing Committee on Children and Youth (SSCCY) submitted a report to the Legislative Assembly in January 2016, which was the culmination of a special project examining child and youth mental health in BC. This report contained 23 recommendations for improving CYMH services that were based on a large volume of public input, and included many recommendations for improving access (Donaldson et al., 2016). The BC Representative for Children and Youth (RCY) also submitted multiple reports between 2011 and 2016 to the Legislative Assembly that contain recommendations for improving access to CYMH treatment, services, and supports (Representative for Children and Youth, 2013, 2014, 2016).

In response to long wait times, the SSCCY recommended setting targets of 30 days from being identified as possibly needing mental health services to receiving a mental health assessment, and the initiation of treatment within the next 30 days (Donaldson et al., 2016). The RCY also made this recommendation specifically for Indigenous CYMH clients (Representative for Children and Youth, 2016). To address difficulty navigating the CYMH system, the SSCCY recommended a "one child, one file" approach to information sharing among care providers, and expanding the use of integrated, collaborative, and multi-disciplinary school- and community-based "hub" sites (similar to headspace in Australia; Donaldson et al., 2016). The RCY has similarly recommended co-locating CYMH services in schools (Representative for Children and Youth, 2016). These sites could also help reduce stigma and make services more youth-friendly, as well as address issues with transitioning from CYMH to adult mental health services if they are structured to allow access up to age 25 (Donaldson et al., 2016). To address the problem of inadequate and inappropriate services, the SSCCY recommended expanding the delivery of CYMH services in rural and remote areas through the use of technology such as tele-health, prioritizing culturally appropriate programs for Indigenous children and youth, prioritizing and integrating the needs of children and youth with special needs in CYMH services, and developing and implementing a specific plan for transition-age youth (Donaldson et al., 2016). The RCY also recommended a special focus on CYMH services for Indigenous children and youth (Representative for Children and Youth, 2014).

QUESTION 1.C.: HOW HAVE THESE STRATEGIES BEEN IMPLEMENTED?

Government plans, such as *Healthy Minds, Healthy People*, and MCFD's strategic plans identify key initiatives designed to improve access to CYMH services that align with or respond to formal

recommendations in the Select Standing Committee report and the RCY reports. For example, MCFD has opened 90 walk-in intake clinics across the province, which are designed to reduce wait times and streamline the intake process (Ministry of Health & Ministry of Children and Family Development, 2014; Province of British Columbia, n.d.). To make it easier for families to find services and navigate the system, MCFD has partnered with the Ministry of Health (MoH) to create an online inventory and map of publicly funded CYMH resources in the province that are available by self-referral (Ministry of Health & Ministry of Children and Family Development, 2014). In addition, MCFD partners with the Provincial Health Services Authority (PSHA) to fund the F.O.R.C.E. Society for Kids' Mental Health (Ministry of Health & Ministry of Children and Family Development, 2014). The F.O.R.C.E. Society provides direct system navigation for families, and in some service delivery areas their Parents in Residence and Youth in Residence also provide support, mentorship, and navigation help for families and youth who are engaged in mental health care (Ministry of Health & Ministry of Children and Family Development, 2014; The F.O.R.C.E. Society for Kids' Mental Health, 2015). To improve access to early intervention, MCFD provides funding to the Canadian Mental Health Association of British Columbia to deliver the Confident Parents, Thriving Kids program, and evidence-based, telephone-delivered intervention provided to parents throughout BC. To improve access to CYMH services in rural and remote areas, MCFD has partnered with the Northern Health Authority, psychiatrists, and BC Children's and Women's Mental Health Program to expand the use of videoconferencing to access psychiatric services (Ministry of Health & Ministry of Children and Family Development, 2014). MCFD has also partnered with the MoH to develop Youth to Adult Mental Health Transition Protocols to assist youth from age 17 until their 21st birthday and their families in making the transition from CYMH services to Adult Mental Health services in a supported, coordinated, and continuous fashion (Ministry of Health & Ministry of Children and Family Development, 2014). MCFD has identified improving the consistency and accessibility of CYMH services as a priority moving forward, including continuing to expand the use of tele-mental health, expanding the Intake Clinic Model to remaining intake clinics in BC, and investigating innovative and flexible approaches to service delivery (Ministry of Children and Family Development, 2015; Ministry of Health & Ministry of Children and Family Development, 2014). In February of 2017 Government announced that MCFD would receive an additional \$15 million per year to improve access to CYMH through hiring of additional practitioners and through additional funding to the F.O.R.C.E. and the Confident Parents, Thriving Kids program. ("\$140 million to improve access, target key mental-health initiatives," 2017). The remainder of this report will focus on identifying practical strategies to support MCFD's goals for improving access to CYMH services and supports.

QUESTION 2: WHERE BARRIERS REMAIN, WHAT STRATEGIES CAN BE USED TO ADDRESS THEM?

Literature relating to access improvement strategies encompasses a broad variety of topics, approaches, and sources. Malla et al. (2016) explain that success in researching, developing, and implementing early

intervention (EI) services for psychotic disorders over the past two decades has encouraged researchers and policy makers to pay greater attention to achieving better outcomes for all mental disorders affecting youth, at all severity levels. This, along with poor access to mental health care for young people in most economically developed countries, has led to youth mental health service reform initiatives in many jurisdictions (Malla et al., 2016). An Ontario Centre of Excellence for Child and Youth Mental Health Evidence In-Sight report regarding access to CYMH services states that there are currently many different access models being used in the field; these vary in their approaches, goals, components, and strategies, and there are currently no best practice guidelines for the creation or implementation of mental health access systems (Ontario Centre of Excellence for Child and Youth Mental Health, 2015a).

Access improvement strategies identified in the literature generally fall into two categories: service management strategies and service delivery strategies, though some strategies incorporate elements of both. Service management strategies focus on increasing the flow of patients through existing services, decreasing wait times, and making services more efficient, without changing the content or delivery methods of interventions offered. Service delivery strategies focus on offering interventions in new formats, venues, and configurations in order to improve their availability, affordability, and/or acceptability. This review synthesizes literature on service management strategies and service delivery strategies, and discusses literature on the implementation of two child and youth mental health service transformation models, the Choice and Partnership Approach (CAPA) and Australia's National Youth Mental Health Foundation, also known as headspace, which incorporate elements of both types of strategy.

SERVICE MANAGEMENT STRATEGIES

Child and youth mental health agencies employ a wide variety of management strategies that are intended to reduce wait times and improve access. An online survey of 113 Canadian agencies providing child mental health services found that while the most common management strategies used were collaborating with other agencies and referring families to self-help resources, only upstream/pre-waitlist strategies, including centralized intake, standardized intake, prevention and early intervention services, triage in the intake process, and coordinating intake with other agencies, were associated with the ability to meet Canadian Psychiatric Association (CPA) benchmarks for wait times, and only for urgent cases (Vallerand & McLennan, 2013).

WAITLIST MANAGEMENT

Apart from strictly IT approaches to managing waitlists (e.g. Findlay, 2012, 2014), there were two other direct approaches to managing wait times found in the literature. One is using an advanced or open access scheduling system, in which patients are offered an appointment the day that they call or within 24 hours (Rose, Ross, & Horwitz, 2011). This model has been tested in primary care clinics, where it has been shown to improve wait times and no-show rates, but effects on patient satisfaction were mixed

(Rose et al., 2011). There is little data on clinical outcomes associated with advanced access scheduling, and reason to believe that it could have a negative impact on outcomes, such as loss to follow-up (Rose et al., 2011). The Ontario Centre of Excellence for Child and Youth Mental Health notes that some changes in implementation would need to be made in order to use advanced access scheduling in a mental health clinic (Ontario Centre of Excellence for Child and Youth Mental Health, 2015b).

The second direct approach to improving the efficiency of waitlists is to use appointment reminders to reduce no-show rates. While the use of phone, text, or sticker reminders has demonstrated reduced non-attendance in pediatric primary care clinics and adult mental health clinics (Arai, Stapley, & Roberts, 2014; Filippidou, Lingwood, & Mirza, 2014; Gurol-Urganci, de Jongh, Vodopivec-Jamsek, Atun, & Car, 2013; Hasvold & Wootton, 2011; McMillan & Jayatunga, 2012), the quality of the evidence that appointment reminders are effective is rated “low to moderate” by Gurol-Urganci et al. (2013). They conclude that the evidence base for appointment reminders is not strong enough to inform policy decisions (Gurol-Urganci et al., 2013). Interestingly, a review examining strategies for improving engagement in children’s mental health treatment found that appointment reminders were the only frequently used strategy *not* associated with increased engagement (Lindsey et al., 2014).

AFTER HOURS SERVICES

Providing services outside of regular office hours has been repeatedly mentioned as a strategy that could make services more youth and family friendly, improving the ability of children, youth, and families to attend appointments and to develop therapeutic relationships (Cox, Smith, Peled, et al., 2013; Hilferty et al., 2015; Kutcher & McLuckie, 2010; Mathias et al., 2015; Representative for Children and Youth, 2013; Select Standing Committee on Children and Youth, 2014). This review did not locate any literature directly examining the effectiveness of this strategy. It is listed as a commonly used service management strategy in Vallerand & McLennan’s 2013 study of Canadian child and youth mental health service providers, where it was not associated with the ability to meet CPA wait time benchmarks. Given the frequency with which the unavailability of treatment outside of traditional office hours is mentioned as barrier to access, this appears to be a major gap in the literature.

INCREASING ENGAGEMENT: INTERIM SERVICES AND PEER SUPPORT

Another approach to wait time reduction is to offer interim services such as books, videos, internet sites, and parenting workshops to families while children are waiting for mental health services, with the goal of keeping parents engaged, providing information, preparing for treatment, and even reducing the need for treatment (Cunningham et al., 2013). A survey of parents’ preferences for hypothetical interim services found that while all parents preferred interim services that helped them understand how agencies work, enhanced their parenting knowledge, gave them updates on their status on the waitlist, and provided information about ways to solve their own difficulties, their preferences for how they received these services varied (Cunningham et al., 2013). 35% of parents preferred learning parenting skills in small face-to-face groups, 29% preferred services delivered via the internet or telephone and

supported by internet groups with other parents, 24% preferred frequent face-to-face contact with weekly progress checks and wait time updates, and 11% preferred less contact, fewer check-ins, and less frequent wait time updates (Cunningham et al., 2013).

The role of peer support workers in improving engagement in mental health services has been growing in recent years, and research into peer support in child and youth mental health suggests that it is a promising model for engaging families and supporting them to participate in services (Garland et al., 2013), though there is not yet a well-established evidence base. A community-based telephone-delivered peer-to-peer support program for parents of youth with emerging behavioral and emotional difficulties increased parental perceived social support and concrete support (January et al., 2016), and a survey of youth and caregivers who used public mental health services in the US found that access to peer advocates was associated with participants feeling that they had better access to services, that services were appropriate, and that they were more likely to participate in services (Radigan, Wang, Chen, & Xiang, 2014). There is an emerging body of research concerning online peer-to-peer support for individuals with serious mental illness: Naslund, Aschbrenner, Marsch, & Bartels (2016) propose a conceptual model to illustrate how online peer-to-peer connections might afford opportunities for individuals with serious mental illness to challenge stigma, increase consumer activation, and access online interventions for mental and physical well-being. Alvarez-Jimenez, Gleeson, Rice, Gonzalez-Blanch, & Bendall (2016) describe the MOST approach, which is a model of social media-based interventions designed to enhance engagement and long-term recovery in youth mental health, especially for young people with psychosis or depression.

CENTRALIZED INTAKE

Centralized intake in child and youth mental health services can be an effective and efficient way to link children and families to appropriate services (Ontario Centre of Excellence for Child and Youth Mental Health, 2011). However, care must be taken in its implementation, since it has the potential to create barriers to access by limiting avenues for intake (Ontario Centre of Excellence for Child and Youth Mental Health, 2011). Despite this possible limitation, it is still the favored intake model, especially for communities with a large service area and a large variety of services (Ontario Centre of Excellence for Child and Youth Mental Health, 2015a). A survey of clients of a centralized intake agency for children's mental health and developmental services in Ontario reported overall client satisfaction (Shaw, Chmiel, Ruman, & Angus, 2013).

COLLABORATIVE CARE

Most research into collaborative care models has focused on partnerships between primary care providers and psychiatrists, though collaborative care can be described as any activity that enables mental health and primary care providers to work together more efficiently (Kates et al., 2011). Collaborative partnerships have been identified as a promising strategy to improve service access and engagement (Garland et al., 2013). A Canadian Psychiatric Association and College of Family Physicians of

Canada position paper on collaborative mental health care states that there is convincing evidence from Canadian projects and international literature that collaborative partnerships offer many short- and long-term patient outcome benefits, naming youth as one population for which these benefits have been identified (Kates et al., 2011). Successful collaborative care programs include some common components, such as:

- use of a care coordinator or case manager;
- access to psychiatric consultation;
- enhanced patient education or access to resources;
- evidence-based treatment guidelines;
- depression and anxiety screening for people with chronic medical conditions;
- skill enhancement programs for primary care providers; and
- access to brief therapies (Kates et al., 2011).

Collaborative care models have been reported to improve access to child psychiatry services (Aupont et al., 2013), and to improve outcomes for adolescents with depression (Richardson et al., 2014). In New Zealand, a free counseling service for youth using a collaborative approach was found to be acceptable and effective in reaching Māori youth and those from lower socioeconomic groups (T. Clark et al., 2014). In northern Ontario, a new shared care mental health service was able to offer services more than 40 days sooner than similar non-shared care sites, and also appeared to contribute to shorter wait times for other outpatient providers in the area (Haggarty, Jarva, Cernovsky, Karioja, & Martin, 2012). All of the studies identified on collaborative care models have significant limitations with regard to the ability to determine causality and generalizability, such as lack of control or comparison groups; longitudinal research is needed to reach a better assessment of the usefulness of these models (Aupont et al., 2013).

SERVICE DELIVERY STRATEGIES

In addition to changing the ways mental health services are *managed*, there are a number of strategies aimed at improving access to care by changing how mental health interventions are *delivered*. This approach is driven by the gap between the availability of evidence-based interventions and the ability to deliver these interventions to those who would benefit from them (Kazdin & Rabbitt, 2013). Currently, long-term, one-to-one, in-person therapy administered by a highly trained professional is the dominant model of mental health service delivery; new delivery methods are being developed that have the potential to reach more underserved individuals than is possible under this model (Duvall, Young, & Duncan, 2012; Kazdin & Rabbitt, 2013). Some of these new methods seek to simply extend the reach of interventions based on the dominant model of service delivery (for example, providing individual sessions via webcam); while others challenge the basic assumption that a long-term one patient/one physician relationship is central to therapeutic change (Kazdin & Rabbitt, 2013; Myers & Vander Stoep, 2017).

BRIEF THERAPY

Brief therapy is a delivery model that dispenses with the idea that effective therapy must consist of a long-term relationship with a professional who is positioned as an expert in the therapeutic process (Duvall et al., 2012). Brief interventions are strength-based, focusing on the client's resources, and only last as long as the client needs them to (Duvall et al., 2012). To be effective in providing quick access to care, brief interventions need to be offered through brief service delivery mechanisms such as walk-in clinics, single-session therapy, intake as first session, extended intake and focused consultation, and direct response service (Duvall et al., 2012). Studies of two walk-in counseling centres in Ontario, one for children and youth, and one for ages 16 and up, found brief interventions and single-session therapy to be effective (Barwick et al., 2013; Stalker, Horton, & Cait, 2012). Clients of the West End Walk-In Counseling Centre for children and youth showed better rates of improvement post-treatment than a control group of usual care clients, and were also more satisfied the service they received (Barwick et al., 2013). Both of these studies had problems with a low response rate for follow-up data, which may have influenced results.

TECHNOLOGY-BASED DELIVERY METHODS

Technology-based strategies for delivering mental health services to children, youth and families are growing exponentially around the world, and have the ability to contribute to better access to care, practitioner capacity, patient and family outcomes, and quality of life (Boydell et al., 2014). However, research into these strategies is still in its infancy. Aboujaoude & Salame (2016), in a review of the evidence base for computerized cognitive behavioral therapy (CBT), online CBT, remote pharmacotherapy, mobile tools, and virtual reality exposure therapy specifically for children and youth conclude that overall, the data from efficacy trials so far are too basic to warrant recommending these strategies where traditional treatment is available. In addition, they point out that the safety of these strategies has not been proven, and cannot be taken for granted (Aboujaoude & Salame, 2016). They do, however, assert that a case can be made for the use of technology-enabled interventions as supplements to face-to-face treatments, or to deliver treatment when face-to-face treatment is unavailable due to distance or cost (Aboujaoude & Salame, 2016).

Four randomized controlled trials (RCTs) of technology-based therapies for children and youth were identified in the present review: telephone-based delivery of the Strongest Families program to participants in Nova Scotia helped to significantly decrease diagnoses of disruptive behavior and anxiety disorders (McGrath et al., 2011); therapist-guided online CBT was shown to be effective for adolescents with obsessive compulsive disorder (Lenhard et al., 2017); SPARX, a computerized CBT intervention for adolescents with depressive symptoms, was shown to be at least as effective as usual care: its use resulted in clinically significant reductions in depression, anxiety, and hopelessness, and improvement in quality of life (Merry et al., 2012); and an RCT of the effects of an internet-based guided self-help Problem

Solving Therapy treatment for adolescents with mild to moderate depression and/or anxiety found no difference compared to a waiting list control group (Hoek, Schuurmans, Koot, & Cuijpers, 2012), though it was noted that this finding may represent a lack of power due to a small sample size. These preliminary studies suggest that technology can be used to successfully deliver mental health therapies to children and youth; the efficacy of programs utilizing technology-based delivery methods may depend more on the content and quality of the intervention being delivered than the delivery method.

A few less rigorous studies in this area were also identified. A scoping review of the use of technology to deliver mental health services to children and youth found high levels of satisfaction among young people, families, and practitioners using telepsychiatry; the authors assert that high satisfaction provides preliminary evidence for the effectiveness of telepsychiatry* (Boydell et al., 2014). Conducting therapy sessions via videoconferencing was found to increase access to care, to enhance rural practitioner capacity, and to be similar to face-to-face sessions in terms of diagnoses and treatment recommendations made, outcomes, and youth confidence with recommendations. Boydell et al. (2014) point out, however, that the literature on videoconferencing tends to focus on child and youth mental health generally, and not specific diagnostic categories, leaving questions about which service delivery methods are best for which particular disorders when using videoconferencing largely unanswered. This scoping review also identified literature supporting the effectiveness of online CBT therapy for addressing and preventing adolescent anxiety and depression, and studies reporting effectiveness of Internet-based programs for treatment of posttraumatic stress, promotion of recovery in first episode psychosis, and reduction of symptoms for eating disorders (Boydell et al., 2014). A pilot study evaluating an internet-based intervention integrating social networking, interactive psychosocial interventions, and interdisciplinary and peer moderation for young people with psychosis (HORYZONS) indicated that its potential to improve long-term recovery is worthy of further investigation (Alvarez-Jimenez et al., 2013), and a survey of children and therapists who used a computerized CBT game (Treasure Hunt) during treatment found high rates of satisfaction with its use for both groups, though a positive bias was identified (Brezinka, 2014). A systematic review of individual synchronous online chat counseling identified three studies that involved children and youth and reported positive outcomes such as

*Using patient satisfaction as an indication of effectiveness is a controversial idea in the literature. Patient satisfaction has been empirically linked with fewer readmissions and fewer days readmitted in adult psychiatric services (Gruss, Rosenheck, & Stolar, 1999), and is considered by some researchers to be an accurate indicator of quality in psychiatric care (e.g. Shipley, Hilborn, Hansell, Tyrer, & Tyrer, 2000). However, other researchers point out that the idea of patient satisfaction has its roots in consumer marketing, and that the science of integrating outcome and quality metrics into patient satisfaction surveys is far from fully developed (Kupfer & Bond, 2012). An study of patient satisfaction at a child and adolescent psychiatric hospital revealed that, for both parents and children, overall satisfaction with services was only weakly correlated with problem improvement (Kaplan, Busner, Chibnall, & Kang, 2001). Reports of patient satisfaction with mental health services should be interpreted with caution: they may provide an indication of accessibility, but not necessarily of effectiveness.

increased well-being, decreased perceived burden and a reduction in distress as measured by a standardized scale (Dowling & Rickwood, 2013). The authors point out that currently, services providing online chat counseling rely mostly on evidence from related fields like telephone and face-to-face care, and conclude that a great deal more research is needed to support the implementation of services like Kid's Helpline's Web counseling and e-headspace, and strong evaluation mechanisms need to be built into these programs in order to establish a solid evidence base (Dowling & Rickwood, 2013).

EMERGING DELIVERY MODELS

Kazdin & Rabbitt (2013) describe six emerging service delivery models, originating from fields outside of mental health professions, that have the potential to be more accessible, affordable, and scalable than currently used mental health delivery models.

- *Task shifting*: this is a method of strengthening and expanding the health care workforce in which specific tasks are shifted, where appropriate, from highly qualified health care workers to health workers with less training and fewer qualifications in order to make more efficient use of the available human resources and scale up service provision (Kazdin & Rabbitt, 2013; World Health Organization, 2008). Task shifting was developed in the context of global health initiatives, particularly in developing countries where the need for services greatly outweighs the professional capacity for providing care: for example, the United Nations has expanded the range of workers recruited for treating HIV/AIDS in Sub-Saharan Africa to include nurses, midwives, and community members who can provide specific services, support others, and help to overcome stigma and discrimination in their communities (Kazdin & Rabbitt, 2013). According to the WHO, task shifting has been shown to be effective and useful in rapidly increasing access to services in high-income as well as resource-constrained economies; however, the WHO cautions that task shifting is only effective when it is implemented alongside other strategies that are designed to increase the total numbers of health workers (Kazdin & Rabbitt, 2013; World Health Organization, 2008). Task shifting has demonstrated some utility in the provision of mental health services: for example, a randomized controlled trial of anxiety and depression treatment in India that used task shifting to deliver stepped-care interventions to more than 2,700 individuals found that trained lay counselors working within a collaborative care model were able to reduce the prevalence of anxiety and depression, suicidal behavior, psychological morbidity, and disability days compared to "treatment as usual" (Kazdin & Rabbitt, 2013; Patel et al., 2011).
- *Disruptive innovations*: this is a concept originating in the business world that refers to a change in a product or service that is not a linear, evolutionary, or incremental step; it "disrupts" an existing market by changing who is served and how the service is provided, by making things simpler and more affordable (Kazdin & Rabbitt, 2013). An example of this is the way that the introduction of digital cameras led to a change in how most people take photos, and disrupted the market for, and business based on, film photography (Kazdin & Rabbitt, 2013). An example of

disruptive innovations in mental health service delivery is the use of smartphones, tablets, the Internet, and videoconferencing to deliver interventions, which can make accessing services more convenient, user-friendly, and immediate (Kazdin & Rabbitt, 2013). Kazdin & Rabbitt (2013) point out that the challenge in developing disruptive innovations in mental health services is making sure that quality is not sacrificed by changing the way services are delivered.

- *Interventions in unconventional (everyday) settings*: this model focuses on expanding care beyond traditional locations for services, such as clinics, hospitals, and outpatient offices, into everyday settings where people already spend time, such as schools, workplaces, homes, churches, hair salons, and barber shops (Kazdin & Rabbitt, 2013). An example is providing school-based mental health treatment and prevention for children and adolescents, though this is now so well-established that schools may no longer be considered an unconventional setting for mental health care (Kazdin & Rabbitt, 2013). A program that trains hairstylists to assess anxiety and depression symptoms and provide appropriate referral information to clients is an example of a mental health intervention in a less conventional setting (Hanlon, 2011; Kazdin & Rabbitt, 2013).
- *Best-buy interventions*: this idea has emerged from the health care economics field to designate interventions for physical illnesses, particularly chronic health conditions and noncommunicable diseases, which are proven to be highly cost-effective, feasible, affordable, and appropriate to implement within a local health system (Kazdin & Rabbitt, 2013). Delineating evidence-based best-buy interventions began as an effort to help countries and policymakers make choices about how to allocate resources for health care; what qualifies as a best buy can vary for a given disorder and country, since the cost of delivering a particular intervention will vary based on the existing health resources and infrastructure (Kazdin & Rabbitt, 2013). As an example, for reducing tobacco use, the WHO has identified tax increases, smoke-free indoor workplaces and public places, health information and warnings, and bans on tobacco advertising, promotion, and sponsorship as best-buy interventions (World Health Organization, 2011). Some best buys for treating mental disorders have been designated: for example, for clinical depression, generic antidepressants, brief psychotherapy, and treating depression in primary care qualify as best buys in low- and middle-income countries (Chisholm, Lund, & Saxena, 2007; Kazdin & Rabbitt, 2013).
- *Lifestyle change*: this refers to interventions which target high-risk behaviors in order to reduce mortality and morbidity, and promote a range of behaviors that can positively affect health (Kazdin & Rabbitt, 2013). Common examples of lifestyle changes are controlling diet, exercising, reducing or eliminating alcohol and nicotine consumption, and participating in activities that can reduce stress; there is growing evidence that lifestyle changes can have a significant impact on physical diseases such as early-stage prostate cancer (Frattaroli et al., 2008; Kazdin & Rabbitt, 2013). Psychologists have been incorporating aspects of lifestyle change into treatment of depression

for many years in the form of exercise, social engagement, and recreational activities (Kazdin & Rabbitt, 2013).

- *Social media*: this refers to Internet-based content that is widely available to the public, including blogs, social networking websites such as Facebook, collaborative projects such as Wikipedia, user-generated content communities such as YouTube, and virtual social worlds such as Second Life (Kazdin & Rabbitt, 2013). These media are used in many ways in health care; for example, to track flulike symptoms and predict patterns in influenza outbreaks; in creating support groups on social networking sites for many different health problems; and in raising awareness of critical issues and providing access to support for individuals who might not otherwise have access to a support network, possibly due to geographical or personal barriers (Kazdin & Rabbitt, 2013). Social media provides many opportunities for delivering mental health interventions: for example, social networking sites have been used to assess suicidality risk in adolescents (Kazdin & Rabbitt, 2013). Social media can facilitate screening for mental health problems as well as assist in coordinating services for individuals who might not have access to conventional mental health care (Kazdin & Rabbitt, 2013).

All of these models have been applied to mental health to varying degrees, though only a few applications in child and youth mental health were cited. The authors assert that a portfolio of overlapping models for delivery of mental health services is necessary, as no one model will never be able to meet all treatment needs (Kazdin & Rabbitt, 2013).

SERVICE TRANSFORMATION MODELS: IMPLEMENTATION DATA

CAPA

The Choice and Partnership Approach (CAPA) is a service transformation model that incorporates elements of collaborative care, lean thinking, and participatory practice (“What is CAPA? – The Choice and Partnership Approach,” n.d.). It was developed for Child and Adolescent Mental Health Services (CAMHS) in the UK, and has been implemented widely in child and youth mental health the UK, Australia, and New Zealand, and in a more limited fashion in Canada and Belgium (Naughton, Carroll, Basu, & Maybery, 2017; “What is CAPA? – The Choice and Partnership Approach,” n.d.). Child and youth mental health services recently implementing CAPA in Nova Scotia and rural Australia report that it has reduced average wait times (S. Clark & Emberly, 2012; Naughton, Basu, O’Dowd, Carroll, & Mayberry, 2015). Two studies of CAMHS services using CAPA in the UK and Australia found that improving the efficiency and speed of services did not negatively impact clinical outcomes for clients (Fuggle et al., 2016; Naughton et al., 2017). S. Clark & Emberly (2012) and Naughton et al. (2015) discuss the role of CAPA in providing a common language and facilitating cultural shifts within child and youth mental health service systems. All articles identified report on CAPA implementations carried out in the real world, and not in controlled experimental settings, which limits their generalizability.

HEADSPACE

Australia's National Youth Mental Health Foundation, also known as headspace, is made up of around 100 youth-friendly walk-in centres across the country offering mental health services, primary care, drug and alcohol services, and vocational and educational assistance (Malla et al., 2016). The headspace model aims to make mental health care more accessible for youth by combining elements of service management strategies like centralized intake and collaborative care with service delivery strategies like brief therapy and technology-based delivery methods (e-headspace). The second independent evaluation of headspace since its introduction was released in 2015 (Hilferty et al., 2015). This mixed methods evaluation examined access and engagement, clinical outcomes of young people who had received headspace services, the program's service delivery model, and the cost effectiveness of the program (Hilferty et al., 2015). The evaluation found that, overall, headspace is accessible, and has been successful in attracting young people from marginalized, at-risk, and traditionally hard-to-reach groups, including Indigenous and rural young people, though it has not been successful in attracting culturally and linguistically diverse (CALD) young people (Hilferty et al., 2015). The evaluation attributes economic and social benefits to headspace treatment, due to a reduction in the number of days lost to illness, a reduction in suicidal ideation and self-harm, and a positive impact on reducing stigma and encouraging help-seeking among young people (Hilferty et al., 2015).

The data reported in this evaluation on the rates of change in psychological distress in headspace clients (distress decreased for 47%, did not change for 29%, and increased for 24%) sparked debate among academics about the effectiveness of headspace services. Jorm (2015) asserts that this rate of improvement is similar to that seen in untreated cases; therefore, in the absence of a control group it is impossible to attribute improvement to headspace treatment, as it may be due to spontaneous remission. He argues that it would be unwise to invest further in the headspace model unless it can be clearly demonstrated that headspace treatment is effective (Jorm, 2015).

McGorry, Hamilton, Goldstone, & Rickwood (2016) respond to Jorm (2015) by stating that prior to the introduction of headspace, young people had the worst access to mental health care of any age group in Australia, and that their symptoms were not improving, so "spontaneous remission wasn't working for them". They also point out that Jorm (2015) cites data on spontaneous remission from adult samples of patients with mild to moderate depression, and argue that this is an inappropriate group to compare headspace clients to (McGorry et al., 2016). They explain that it is extremely difficult to assemble a control group to compare headspace clients to because access levels prior to headspace and in areas where it does not yet exist are so poor (McGorry et al., 2016).

Jorm (2016), in turn, cites data from various sources to argue that Australian youth do not in fact have poor access to mental health care apart from headspace, that headspace is not adequately engaging young people, that evidence supporting the effectiveness of headspace treatment is weak, and that no data have been published to support some claims about headspace, such as that it has substantially

improved the number of days lost to illness and self-harm (note: the 2015 Hilferty et al. evaluation published data on this). He calls for more investment in exploring prevention services, the promotion of evidence-based self-help interventions, improving social support, and focus on reducing the “quality gap” (improving the quality of services for those with more severe mental health needs) instead of the “treatment gap” (increasing the numbers of young people with milder disorders in treatment).

Another opinion article, based on data from a 2009 evaluation of headspace, argues that because of headspace’s poor record of integrating and coordinating services for young people in conjunction with state-based mental health services, headspace centres should be aligned with the states and territories, as that is the level of government responsible for clinical services in Australia (Allison, Bastiampillai, & Goldney, 2016).

GAPS AND CONSIDERATIONS

A few points relating to this body of research warrant discussion: first, it should be pointed out that almost all of the research identified in this review was carried out and interpreted according to a positivist research paradigm, which considers RCTs to be the gold standard of evidence, and defines improvement and recovery primarily by numerical outcome data (Williams, 2015). This does not leave much room for alternative interpretations, individual service users’ narratives, or qualitative dialogues; adding more research based in an interpretive paradigm may help shape service-based cultures, change how services are evaluated, and improve the richness of the research in the field (Williams, 2015). This lack of qualitative research highlights the fact that the research into access improvement strategies in general is still in beginning stages: there are very few rigorous studies, RCT or otherwise, evaluating the effectiveness of these strategies in child and youth mental health settings.

Second, mental health cannot be separated from social and biological health, and cannot be adequately understood in isolation from them (Canadian Alliance on Mental Illness and Mental Health, 2016). Risk factors for many common mental disorders are linked to social inequalities, causing the poor and disadvantaged to suffer disproportionately; policy-making at all levels of government should take this into account and strive to improve the conditions of everyday life, across all stages of life, in order to reduce inequalities (Allen, Balfour, Bell, & Marmot, 2014). In Canada, this is particularly relevant in light of the harmful effects of colonization and discriminatory government policies on Indigenous people, families, and communities. The intergenerational trauma caused by policies and practices such as residential schools, medical experimentation, and the apprehension of Indigenous children at disproportionate rates have contributed to a need for services in Indigenous communities that is greater and more complex than in non-Indigenous communities – a need that is often not met (Representative for Children and Youth, 2017). The RCY’s March 2017 report *Delegated Aboriginal Agencies: How resourcing affects service delivery* identifies Child and Youth Mental Health services in rural and remote areas of BC as a major area where the lack of reliable and adequate funding of Delegated Aboriginal Agencies has caused a shortage

of services for Indigenous children and families. The Truth and Reconciliation Commission's Calls to Action include a call for all levels of government to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous government policies, and to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities on a number of indicators, including suicide, mental health, addictions, and the availability of appropriate health services (Truth and Reconciliation Commission, 2015).

Third, in the push to improve access to child and youth mental health services, it is important to make sure that evidence-based treatment is not traded for less proven or ineffective treatments in order to reduce wait times (McLennan, 2015). McLennan (2015) outlines two pathways that could lead to reduced wait times *and* worse clinical outcomes. One pathway could occur if the wait time is shortened to an intervention that has more harmful than beneficial effects: an example of this is grouping some youth together for interventions, which empirical literature has associated with the risk of "deviancy training" (McLennan, 2015). A second pathway to worse outcomes could occur if wait time is reduced to interventions that are ineffective, thereby diverting resources from the delivery of effective interventions (McLennan, 2015). In order to make sure that improving wait times for services is also improving clinical outcomes, it is important to deliver evidence-based interventions, and to measure clinical outcomes: it is impossible to manage what is not measured (Canadian Alliance on Mental Illness and Mental Health, 2016; McLennan, 2015).

CONCLUSION

Timely access to effective and appropriate mental health care is one of the important services that MCFD is mandated to provide for BC's children and youth. Consistent with Government's strategic plans (e.g., Ministry of Health Services, & Ministry of Children and Family Development, 2010), MCFD has taken steps to improve access to CYMH services and to implement a number of strategies designed to break down systemic barriers to services, with many of the actions aligning with recommendations from the Representative for Children and Youth and the Select Standing Committee on Children and Youth. A scoping review of the literature on access improvement strategies for child and youth mental health services reveals that research in this area is generally in its infancy. Some promising strategies have been introduced, but the evidence base for most of them is not yet well developed enough to support policy decisions. Collaborative care, centralized intake, brief therapy, peer support, some computerized CBT programs, and offering tele-mental health via telephone or videoconferencing are strategies that have demonstrated effectiveness. Both the CAPA and headspace models have had success in improving access to mental health care for children and youth, though they have each faced implementation challenges. Continued improvement in access to mental health services, supports, and treatment for all of BC's children and youth will require further research, thoughtful implementation of evidence-based strategies and careful measurement of results.

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APPENDIX: ANNOTATED BIBLIOGRAPHY

ACCESS IMPROVEMENT STRATEGIES

<p>2016</p> <p>Lit review</p> <p>Australia, Ireland, UK, Canada</p>	<p>Malla, A., Iyer, S., McGorry, P., Cannon, M., Coughlan, H., Singh, S., ... Joober, R. (2016). From early intervention in psychosis to youth mental health reform: A review of the evolution and transformation of mental health services for young people. <i>Social Psychiatry and Psychiatric Epidemiology</i>, 51(3), 319–326. https://doi.org/10.1007/s00127-015-1165-4</p> <p>Review reporting on recent developments in youth mental health encouraged by progress in the field of early intervention in psychotic disorders, research in deficiencies in the current system, and social advocacy. Outlines the state of current knowledge, and the research and policy responses across Australia, Ireland, the UK, and Canada. Includes a discussion how each country has responded to the principal challenges associated with improving youth mental health services, with a description of the ACCESS network in Canada.</p>
<p>2015</p> <p>Non-systematic review</p>	<p>Ontario Centre of Excellence for Child and Youth Mental Health. (2015a). <i>Evidence In-Sight: Access to child and youth mental health services</i>. Retrieved from: www.excellenceforchildandyouth.ca</p> <p>Non-systematic search and summary of the research and grey literature on the topics of how access is conceptualized in the literature with regard to child and youth mental health; best practices and current models for access; what is currently working to support access in the field of child and youth mental health; and core components of access in other sectors. Findings included: barriers to access are well documented, but access itself has not been well conceptualized; access is influenced by a variety of factors such as time, cost, and type of services being accessed; most research focuses on primary care providers as the most common access point in adult mental health; there are many different access models; and for any model of access to be effective, sectors should work closely together to follow similar strategies. Describes models of access and centralized intake.</p>

SERVICE MANAGEMENT STRATEGIES

<p>2013</p> <p>Online survey</p>	<p>Vallerand, I. A., & McLennan, J. D. (2013). Child and adolescent mental health service management strategies that may influence wait times. <i>Journal of Canadian Academic Child and Adolescent Psychiatry</i>, 22(May), 159. Retrieved from</p>
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Canada	<p>http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647633/</p> <p>Online survey of 113 Canadian agencies providing child mental health services to determine which strategies they use to manage service demands, and whether these strategies are related to meeting CPA benchmarks for wait times. Most commonly used strategies were collaborating with other agencies and referring families to self-help resources. The use of more upstream/pre-waitlist strategies (i.e. standardizing the intake process, centralizing the intake process, providing early intervention services, incorporating triage into the intake process, providing prevention services, and coordinating intake function with other agencies) was related to the ability to meet CPA benchmarks, but only for urgent cases. Other strategies did not demonstrate relationships to wait times variables.</p>
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WAITLIST MANAGEMENT

<p>2014</p> <p>Scoping review</p> <p>UK</p>	<p>Arai, L., Stapley, S., & Roberts, H. (2014). "Did not attends" in children 0-10: A scoping review. <i>Child: Care, Health and Development</i>. https://doi.org/10.1111/cch.12111</p> <p>Scoping review of UK-based research on non-attendance. Includes a review of initiatives to reduce non-attendance. All literature since 2011 that was identified regarding attendance improvement initiatives involved appointment reminders via phone, text, or stickers, in general and specialty pediatric clinics. Review also cites some older studies (2004, 2006, 2007) on initiatives in child and youth mental health outpatient clinics.</p>
<p>2014</p> <p>Description of project</p> <p>UK</p>	<p>Filippidou, M., Lingwood, S., & Mirza, I. (2014). Reducing non-attendance rates in a community mental health team. <i>BMJ Quality Improvement Reports</i>, 3(1), u202228.w1114-u202228.w1114. https://doi.org/10.1136/bmjquality.u202228.w1114</p> <p>Description of a service improvement project to reduce non-attendance at a UK community mental health outpatient clinic using quality improvement techniques. Consultation with patients resulted in introducing text message reminders, which increased attendance rates. Lack of statistical testing is a limitation.</p>
<p>2013</p> <p>Systematic review, RCTs</p> <p>Australia, China,</p>	<p>Gurol-Urganci, I., de Jongh, T., Vodopivec-Jamsek, V., Atun, R., & Car, J. (2013). Mobile phone messaging reminders for attendance at scheduled healthcare appointments (review). <i>Cochrane Database of Systematic Reviews</i>, (12). https://doi.org/10.1002/14651858.CD007458</p> <p>Systematic review of 8 RCTs of using text message and phone call reminders.</p>

Scotland, England, Kenya, Malaysia	Low to moderate quality evidence shows that text message reminders increase attendance. Authors conclude that current evidence is not strong enough to decisively inform policy decisions.
2011 Systematic review Australia, Brazil, China, Denmark, Ireland, Malaysia, Netherlands, New Zealand, Switzerland, UK, US	Hasvold, P. E., & Wootton, R. (2011). Use of telephone and SMS reminders to improve attendance at hospital appointments: A systematic review. <i>Journal of Telemedicine and Telecare</i> , 17(7), 358–64. https://doi.org/10.1258/jtt.2011.110707 Systematic review of 29 studies published in 2000 or later in English, Danish, Swedish, or Norwegian finds that the weighted mean relative change in non-attendance was 34% of the baseline non-attendance rate when telephone and SMS reminders were used for hospital appointments with patients of all ages.
2014 Systematic review, RCTs US, unspecified countries	Lindsey, M. A., Brandt, N. E., Becker, K. D., Lee, B. R., Barth, R. P., Daleiden, E. L., & Chorpita, B. F. (2014). Identifying the common elements of treatment engagement interventions in children’s mental health services. <i>Clinical Child and Family Review</i> , 17, 283–298. http://doi.org/10.1007/s10567-013-0163-x Review of 40 studies of family engagement interventions in children’s mental health services, with the purpose of identifying their common elements. The most frequently identified engagement practice elements were <i>assessment, accessibility promotion, psychoeducation about services, homework assignment, and appointment reminders</i> . <i>Assessment</i> and <i>accessibility promotion</i> were present in at least 50% of treatment groups that outperformed control groups in RCTs. All of these frequently identified elements, with the exception of <i>appointment reminders</i> , had a high likelihood of being associated with winning treatments when they were used.
2012 Abstract UK	McMillan, R., & Jayatunga, R. (2012). Reducing non-attendance rates in the general paediatric clinic. <i>Archives of Disease in Childhood</i> , 97, A110. https://doi.org/10.1136/archdischild-2012-301885.260 Patients in an NHS general pediatric clinic were given sticker reminders for follow-up appointments, which reduced the non-attendance rate to 9.2% compared to the control group rate of 18.4%.
2015 Non-systematic	Ontario Centre of Excellence for Child and Youth Mental Health. (2015b). <i>Evidence In-Sight: Selected strategies to help manage mental health service waiting lists</i> . Retrieved from www.excellenceforchildandyouth.ca

review	<p>Non-systematic search and summary of research and grey literature on the topic of whether advanced access, computerized CBT, and brief services are evidence informed strategies to manage waitlists. For each of these three strategies, evidence was identified to suggest that they have the potential to improve wait times in mental health clinics. Results detail some of the considerations for implementing each strategy.</p>
2011 Systematic review UK, US	<p>Rose, K. D., Ross, J. S., & Horwitz, L. I. (2011). Advanced access scheduling outcomes. <i>Archives of Internal Medicine</i>, 171(13), 1150–1159.</p> <p>A systematic review of 28 advanced access scheduling studies concludes that they support benefits to wait time and no-show rates; however, patient satisfaction was mixed, and data on clinical outcomes and loss to follow up were lacking.</p>

INCREASING ENGAGEMENT: INTERIM SERVICES AND PEER SUPPORT

2016 Commentary	<p>Alvarez-Jimenez, M., Gleeson, J. F., Rice, S., Gonzalez-Blanch, C., & Bendall, S. (2016). Online peer-to-peer support in youth mental health: seizing the opportunity. <i>Epidemiology and Psychiatric Sciences</i>, 25, 123–126. http://doi.org/10.1017/S204579601500106</p> <p>Commentary on Naslund et al. (2016). Discusses opportunities to integrate research with user-led interventions and advance a science of social media interventions in mental health, and provides a brief description of a new model of social media-based interventions developed to enhance engagement and long-term recovery in youth mental health (the MOST approach). Includes references to an emerging evidence base indicating that people with serious mental illness take advantage of opportunities provided by social media.</p>
2013 Online survey, discrete choice conjoint experiment Ontario	<p>Cunningham, C. E., Chen, Y., Deal, K., Rimas, H., McGrath, P., Reid, G., ... Corkum, P. (2013). The interim service preferences of parents waiting for children's mental health treatment: A discrete choice conjoint experiment. <i>Journal of Abnormal Child Psychology</i>, 41(6), 865–877. https://doi.org/10.1007/s10802-013-9728-x</p> <p>Survey of 1,059 parents in Ontario investigating what types of hypothetical interim services parents would prefer while their children were on waiting lists for mental health services. 35% of parents preferred learning parenting skills in small face-to-face groups, 29% preferred services delivered via the internet or telephone and supported by internet groups with other parents,</p>

	<p>24% preferred frequent face-to-face contact with weekly progress checks and wait time updates, and 11% preferred less contact, fewer check-ins, and less frequent wait time updates.</p>
<p>2013 Selective review US</p>	<p>Garland, A. F., Haine-Schlagel, R., Brookman-Frazee, L., Baker-Ericzen, M., Trask, E., & Fawley-King, K. (2013). Improving community-based mental health care for children: Translating knowledge into action. <i>Administration and Policy in Mental Health and Mental Health Services Research</i>, 40(1), 6–22. http://doi.org/10.1007/s10488-012-0450-8</p> <p>Selective review highlighting and synthesizing empirically supported knowledge of strategies to improve community-based mental health care for children and families in the US. Discusses evidence for an array of promising strategies to improve service access and engagement, delivery of evidence-based strategies, and outcome accountability. Promising strategies to improve service access and engagement include improving the integration of behavioral health services with primary care and education, and the use of professional peer family advisors.</p>
<p>2016 Pre/post test US</p>	<p>January, S. A. A., Duppong Hurley, K., Stevens, A. L., Kutash, K., Duchnowski, A. J., & Pereda, N. (2016). Evaluation of a community-based peer-to-peer support program for parents of at-risk youth with emotional and behavioral difficulties. <i>Journal of Child and Family Studies</i>, 25(3), 836–844. http://doi.org/10.1007/s10826-015-0271-y</p> <p>Study using a pre-/post-test design to evaluate a community-based peer-to-peer support prevention program delivered via telephone to 139 parents of youth with emerging behavioral and emotional difficulties. Intervention increased parental perceived social support and concrete support over time, as a function of level of involvement and intervention adherence. Lack of comparison group and reliance on self-report of outcomes may limit generalizability.</p>
<p>2016 Commentary</p>	<p>Naslund, J. A., Aschbrenner, K. A., Marsch, L. A., & Bartels, S. J. (2016). The future of mental health care: peer-to-peer support and social media. <i>Epidemiology and Psychiatric Sciences</i>, 25(2), 113–122. http://doi.org/10.1017/S2045796015001067</p> <p>Commentary article proposing a conceptual model to illustrate how online peer-to-peer connections may afford opportunities for individuals with SMI to challenge stigma, increase consumer activation, and access online interventions for mental and physical well-being.</p>
<p>2014</p>	<p>Radigan, M., Wang, R., Chen, Y., & Xiang, J. (2014). Youth and caregiver access to</p>

<p>Survey US</p>	<p>peer advocates and satisfaction with mental health services. <i>Community Mental Health Journal</i>, 50, 915-921. http://doi.org/10.1007/s10597-014-9709-8</p> <p>Survey examining associations between reported access to a youth or family advocate and perceptions of satisfaction with mental health services among youth and caregivers who utilized public mental health services in New York State in 2012. Access to peer advocates was associated with more satisfaction in the domains of access to services, appropriateness of services, participation in services, and overall/global satisfaction. Cross-sectional nature of the survey limits ability to determine causation.</p>
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CENTRALIZED INTAKE

<p>2011 Non-systematic review</p>	<p>Ontario Centre of Excellence for Child and Youth Mental Health. (2011). <i>Evidence In-Sight request summary: Best practices in mental health intake and referral.</i></p> <p>Non-systematic search and summary of research and grey literature on the topic of best practices in providing a centralized intake to services for child and youth mental health care, and whether a centralized point of access is an evidence-informed way to do intake. Discusses different models and standards for centralized intake services, and implementation considerations. Concludes that centralized intake is effective and efficient, but no single model fits all contexts, and there is a possibility that centralizing intake may create barriers to access by limiting avenues for intake. Though not stated explicitly, this research was likely done for Contact Brant.</p>
<p>2013 Internal evaluation Ontario</p>	<p>Shaw, S., Chmiel, G., Ruman, S., & Angus, J. (2013). <i>Evaluating the Provision of Single Point Access to Children’s Services in Brant.</i></p> <p>Internal evaluation of Contact Brant, a single point access agency for children’s mental health and children’s developmental services in the County of Brant, Ontario. One purpose of the evaluation was to “create a unique evidence-informed intake system informed by our own expertise and by input from other models of intake in Ontario that will assist the children’s mental health system as a whole given the lack of existing research-based literature on access.” Project established user satisfaction benchmarks, and authors report that overall client satisfaction appears to support the literature that centralized intake is an effective and efficient way to link individuals to appropriate services.</p>

COLLABORATIVE CARE

<p>2013</p> <p>Prospective cohort study</p> <p>US</p>	<p>Aupont, O., Doerfler, L., Connor, D. F., Stille, C., Tisminetzky, M., & McLaughlin, T. J. (2013). A collaborative care model to improve access to pediatric mental health services. <i>Administration and Policy in Mental Health and Mental Health Services Research</i>, 40(4), 264–273. http://doi.org/10.1007/s10488-012-0413-0</p> <p>Prospective cohort design study to determine whether a collaborative care model known as Targeted Child Psychiatric Services (TCPS), designed for primary care pediatricians and child psychiatrists, was associated with improved access to child psychiatry services; also examined the potential of TCPS to identify optimal care settings for pediatric mental health care, and whether pediatricians appeared as likely to accept children back into their practices at discharge from TCPS depending on diagnostic category. Diagnostic classes examined were ADHD, depression, and anxiety. Authors conclude that TCPS could serve as a feasible model of care that addresses barriers in accessing pediatric mental health services. Study did not include a control or comparison group; longitudinal research with this model should be done to reach a fuller assessment of its clinical usefulness.</p>
<p>2014</p> <p>Pre/post test</p> <p>New Zealand</p>	<p>Clark, T., Johnson, E. A., Kekus, M., Newman, J., Patel, P. S., Fleming, T., & Robinson, E. (2014). Facilitating Access to Effective and Appropriate Care for Youth With Mild to Moderate Mental Health Concerns in New Zealand. <i>Journal of Child and Adolescent Psychiatric Nursing</i>, 27, 190–200. http://doi.org/10.1111/jcap.12095</p> <p>Quasi-experimental pre-/post-intervention design was used to explore the impact of facilitated access to free counseling support among 581 culturally diverse youth aged 10-24 (“Your Choice” program). A multidisciplinary and collaborative triage approach was used. Authors conclude that the strategy was effective and acceptable, especially for Māori youth and those from lower socioeconomic groups, to reduce mild to moderate mental health symptoms and concerns. Strengths of the program included its relative simplicity and cost-effectiveness, its single point of entry for varied mental health needs, and the low threshold for accepting referrals. No control group.</p>
<p>2012</p> <p>Chart review study</p> <p>Ontario</p>	<p>Haggarty, J. M., Jarva, J. A., Cernovsky, Z., Karioja, K., & Martin, L. (2012). Wait time impact of co-located primary care mental health services: The effect of adding collaborative care in northern Ontario. <i>Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie</i>, 57(1), 29. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22296965</p>

	Retrospective chart reviews of one new shared care site and four existing non-shared services showed that the shared care site offered services more than 40 days sooner and its introduction appeared to help reduce wait times for the non-shared care sites. Limitations of the data preclude attributing this change solely to the new shared care clinic.
2011 Position paper Canada	Kates, N., Mazowita, G., Lemire, F., Jayabarathan, A., Bland, R., Selby, P., ... Audet, D. (2011). The evolution of collaborative mental health care in Canada: A shared vision for the future. <i>Canadian Journal of Psychiatry</i> , 56(5), 1–10. Position paper developed by the Canadian Psychiatric Association and the College of Family Physicians of Canada Collaborative Working Group on Shared Mental Health Care; focuses on collaborative partnerships between family physicians and psychiatrists. Discusses models of collaboration, the evidence base for the effectiveness of collaborative partnerships, barriers to implementing collaborative partnerships, a vision of an integrated system, and what changes will be required to achieve this vision.
2014 RCT US	Richardson, L. P., Ludman, E., McCauley, E., Lindenbaum, J., Larison, C., Zhou, C., ... Katon, W. (2014). Collaborative care for adolescents with depression in primary care: A randomized clinical trial. <i>Jama</i> , 312(8), 809–816. http://doi.org/10.1001/jama.2014.9259 Randomized clinical trial to determine whether a 12-month collaborative care intervention for adolescents (13-17 years) with depression improved depressive outcomes compared with usual care. Intervention youth, compared to those randomized to receive usual care, had greater improvement in depressive symptoms at 12 months. Study sample was English speakers who were mostly white and female from a single integrated care system, which may limit generalizability.

SERVICE DELIVERY STRATEGIES

2017 Commentary	Myers, K., & Vander Stoep, A. (2017). i-Therapy: Asynchronous telehealth expands access to mental health care and challenges tenets of the therapeutic process. <i>Journal of the American Academy of Child & Adolescent Psychiatry</i> , 56(1), 5–7. http://doi.org/10.1016/j.jaac.2016.11.001 Editorial on Lenhard et al.'s (2017) paper describing a newly evolved model of i-therapy that uses asynchronous telehealth. Discusses advantages and shortcomings of i-therapy, and how Lenhard et al.'s findings challenge our conceptualization of therapeutic change: perhaps the one patient/one
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	physician relationship is not central to therapeutic change.
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BRIEF THERAPY

2013 Exploratory evaluation Ontario	<p>Barwick, M., Urajnik, D., Sumner, L., Cohen, S., Reid, G., Engel, K., & Moore, J. E. (2013). Profiles and service utilization for children accessing a mental health walk-in clinic versus usual care. <i>Journal of Evidence-Based Social Work, 10</i>(4), 338–52. http://doi.org/10.1080/15433714.2012.663676</p> <p>Exploratory evaluation of the West End Walk-In Counseling Centre for children and youth, which offered brief interventions or single-session psychotherapy to children 4 to 18 years of age. Children who accessed the walk-in clinic, compared to a comparison group who accessed usual care, had more severe behavioral/emotional adjustment and functioning at baseline, and also steeper rates of improvement post-treatment. Walk-in clients found the wait time for service more reasonable, felt the service addressed concerns, and had higher regard for counselor availability and cultural sensitivity of the service than usual care clients. A relatively small sample of usual care clients, and issues with client retention to the study and collecting follow-up data may have impacted results.</p>
2012 Report Canada	<p>Duvall, J., Young, K., & Duncan, D. (2012). <i>No more, no less: Brief mental health services for children and youth.</i></p> <p>Policy-ready paper initiated by the Ontario Centre of Excellence for Child and Youth Mental Health, discussing the potential of brief therapies and brief service delivery mechanisms to improve access to quality child and youth mental health services. Includes a discussion of the evidence base for solution-focused brief therapy (SFBT) and brief narrative therapy, and a case study of brief services provided at the Hincks-Dellcrest Centre in Toronto. Discusses evaluations of walk-in clinics, as well as limitations of brief services, and policy recommendations.</p>
2012 Survey Ontario	<p>Stalker, C., Horton, S., & Cait, C.-A. (2012). Single-session therapy in a walk-in counseling clinic: A pilot study. <i>Journal of Systemic Therapies, 31</i>(1), pp. https://doi.org/10.1521/jsyt.2012.31.1.38</p> <p>Survey of walk-in counseling clients age 16 and up at a clinic in Kitchener-Waterloo to learn more about the clinical effectiveness of single-session therapy as delivered in a walk-in clinic, and to better understand how to improve the quality of research on this model. Follow-up data suggested that clients showed a decrease in distress, improvement in general functioning, decreased use of health services, and increased use of other social services</p>

	one and four months after the walk-in visit. Authors discuss ideas of how to strengthen studies of the effectiveness of single-session therapy provided in walk-in counseling clinics.
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TECHNOLOGY-BASED DELIVERY METHODS

2016 Lit review	<p>Aboujaoude, E., & Salame, W. (2016). Technology at the Service of Pediatric Mental Health: Review and Assessment. <i>The Journal of Pediatrics</i>, 171, 20–24. https://doi.org/10.1016/j.jpeds.2015.12.009</p> <p>Review of the evidence base for computerized CBT, online therapy, remote pharmacotherapy, mobile tools, and virtual reality exposure therapy. Authors conclude that, overall, the evidence is insufficient to recommend these delivery methods where traditional treatment is available; however, it does support using technology as a supplement to face-to-face treatment, and as a delivery method when face-to-face treatment is unavailable due to geographic distance or cost.</p>
2013 Pilot study Australia	<p>Alvarez-Jimenez, M., Bendall, S., Lederman, R., Wadley, G., Chinnery, G., Vargas, S., ... Gleeson, J. F. (2013). On the HORYZON: Moderated online social therapy for long-term recovery in first episode psychosis. <i>Schizophrenia Research</i>, 143(1), 143–149. http://doi.org/10.1016/j.schres.2012.10.009</p> <p>Pilot study evaluating HORYZONS, an internet-based intervention designed for young people with psychosis. The intervention integrates peer-to-peer social networking, individually tailored interactive psychosocial interventions, and expert interdisciplinary and peer moderation in a coherent platform designed to improve long-term outcomes in first episode psychosis (FEP). Results indicate that HORYZONS is feasible, engaging, and safe, and may augment social connectedness and empowerment in FEP, and that its potential to improve long-term recovery is worthy of further investigation.</p>
2014 Email questionnaire Switzerland, Germany, Belgium, Netherlands, Egypt	<p>Brezinka, V. (2014). Computer games supporting cognitive behaviour therapy in children. <i>Clinical Child Psychology and Psychiatry</i>, 19(1), 100–10. http://doi.org/10.1177/1359104512468288</p> <p>Evaluation of the applicability and appropriateness of the game <i>Treasure Hunt</i> in enhancing CBT treatment for children with various mental health problems. Children were satisfied with the use of the game during treatment; therapists judged it as helpful in explaining CBT concepts, used it as reinforcement, reported that it enhanced child motivation for therapy, and strengthened the therapeutic relationship with the child. A positive bias was identified, as therapists with a positive attitude toward therapeutic</p>

	<p>computer games may have been more likely to participate. Briefly discusses a few other CBT-based computer games that are under development around the world.</p>
<p>2014</p> <p>Scoping review</p> <p>US, Australia, UK, Canada, Netherlands, Sweden, Finland, New Zealand</p>	<p>Boydell, K. M., Hodgins, M., Pignatiello, A., Teshima, J., Edwards, H., & Willis, D. (2014). Using technology to deliver mental health services to children and youth: A scoping review. <i>Journal of the Canadian Academy of Child & Adolescent Psychiatry</i>, 23(PG-87-99), 87–99.</p> <p>Scoping review of 126 studies on the use of technology in mental health services for children and youth. Authors conclude that the use of technologies including videoconferencing, telephone and mobile phone applications, and internet-based applications play a major role in the delivery of mental health services and supports to children and youth. These strategies are proliferating around the world, thus it is critical to study their impact and effectiveness.</p>
<p>2013</p> <p>Systematic review</p> <p>Australia, Canada, Netherlands, UK, US</p>	<p>Dowling, M., & Rickwood, D. (2013). Online counseling and therapy for mental health problems: A systematic review of individual synchronous interventions using chat. <i>Journal of Technology in Human Services</i>, 31, 1–21. http://doi.org/10.1080/15228835.2012.728508</p> <p>Systematic review of evidence for the effectiveness of individual synchronous online chat counseling and therapy that was independent of web-based therapy programs. Three of the six studies identified involved children and youth. Authors state that online chat appears to be effective overall, but research in this area needs to focus more on children and younger adolescents, and more research and strong evaluation designs are required to support the implementation of services such as Kid’s Helpline’s Web Counseling or e-headspace.</p>
<p>2012</p> <p>RCT</p> <p>Netherlands</p>	<p>Hoek, W., Schuurmans, J., Koot, H. M., & Cuijpers, P. (2012). Effects of Internet-Based Guided Self-Help Problem-Solving Therapy for Adolescents with Depression and Anxiety: A Randomized Controlled Trial. <i>PLoS ONE</i>, 7(8), 1–7. http://doi.org/10.1371/journal.pone.0043485</p> <p>RCT evaluating the effects of preventive internet-based guided self-help Problem Solving Therapy (PST) for adolescents with mild to moderate symptoms of depression and/or anxiety compared to a waiting list control group. No differences were found between groups; results did not support the assumption that the intervention was effective in reducing depression and anxiety in comparison to the control group. Finding could represent lack of power, as there were only 45 participants in the trial.</p>

<p>2017</p> <p>RCT</p> <p>Sweden</p>	<p>Lenhard, F., Andersson, E., Mataix-Cols, D., Rück, C., Vigerland, S., Högström, J., ... Serlachius, E. (2017). Therapist-guided, internet-delivered cognitive-behavioral therapy for adolescents with obsessive-compulsive disorder: A randomized controlled trial. <i>Journal of the American Academy of Child & Adolescent Psychiatry</i>, 56(1), 10–19.e2. https://doi.org/10.1016/j.jaac.2016.09.515</p> <p>RCT of therapist-guided i-CBT showed that it was a promising low-intensity intervention for adolescents with OCD. Authors state that this technology has the potential to increase access to CBT and might be particularly useful in a stepped-care approach. Results may not be generalizable to more complex patient populations seen in specialist OCD clinics.</p>
<p>2011</p> <p>RCTs</p> <p>Nova Scotia</p>	<p>McGrath, P. J., Lingley-Pottie, P., Thurston, C., MacLean, C., Cunningham, C., Waschbusch, D. A., ... Chaplin, W. (2011). Telephone-based mental health interventions for child disruptive behavior or anxiety disorders: Randomized trials and overall analysis. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i>, 50(11), 1162–1172. https://doi.org/10.1016/j.jaac.2011.07.013</p> <p>Three practical RCTs to determine whether distance interventions provided by nonprofessionals could significantly decrease the proportion of children diagnosed with disruptive behavior or anxiety disorders compared with usual care. Telephone-based treatments (Strongest Families) to participants in Nova Scotia resulted in significant decreases in diagnoses compared to usual care. Study was done in a single center, so generalization to other regions should be done cautiously.</p>
<p>2012</p> <p>RCT</p> <p>New Zealand</p>	<p>Merry, S. N., Stasiak, K., Shepherd, M., Frampton, C., Fleming, T., & Lucassen, M. F. G. (2012). The effectiveness of SPARX, a computerised self help intervention for adolescents seeking help for depression: randomised controlled non-inferiority trial. <i>BMJ (Clinical Research Ed.)</i>, 344(7), 1-16. http://doi.org/10.1136/bmj.e2598</p> <p>Multicenter RCT non-inferiority trial to evaluate whether SPARX, a computerized CBT intervention could reduce depressive symptoms in help-seeking adolescents as much or more than usual care. Participants were 187 adolescents aged 12-19. Results showed that SPARX was not inferior to treatment as usual; authors conclude that it is a potential alternative to usual care, and could be used to address some of the unmet demand for treatment. Treatment as usual group was heterogeneous and did not have good data on adherence.</p>

EMERGING DELIVERY MODELS

<p>2013</p> <p>Lit review</p>	<p>Kazdin, A. E., & Rabbitt, S. M. (2013). Novel Models for Delivering Mental Health Services and Reducing the Burdens of Mental Illness. <i>Clinical Psychological Science</i>, 1(2), 170–191. https://doi.org/10.1177/2167702612463566</p> <p>Review article highlighting several models for delivering services from outside the mental health professions that are more affordable and accessible than the dominant model (i.e. individual therapy by a highly trained professional), and can be scaled up. These models include task shifting, disruptive innovations, interventions in everyday settings, best-buy interventions, lifestyle changes, and social media.</p>
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SERVICE TRANSFORMATION MODELS: IMPLEMENTATION DATA

CAPA

<p>2012</p> <p>Magazine article</p> <p>Nova Scotia</p>	<p>Clark, S., & Emberly, D. (2012). Reimagining a system of mental health care for children and youth: The implementation of the Choice and Partnership Approach at the IWK health centre. <i>Psynopsis, the Magazine of the Candian Psychological Association</i>, 16–17.</p> <p>Magazine article about the adoption and implementation of CAPA in the mental health and addictions program at the IWK Health Centre. CAPA has significantly reduced wait times and access to services: from wait times of over 20 months to first contact before CAPA to 3 months after two quarters of CAPA. Additionally, the authors state that CAPA has allowed the program to understand its clients' treatment needs better than it did before, and that this has contributed to an ongoing cultural shift within their system.</p>
<p>2016</p> <p>Multi-method evaluation</p> <p>UK</p>	<p>Fuggle, P., McHugh, A., Gore, L., Dixon, E., Curran, D., & Cutinha, D. (2016). Can we improve service efficiency in CAMHS using the CAPA approach without reducing treatment effectiveness? <i>Journal of Child Health Care</i>, 20(2), 195-204. https://doi.org/10.1177/1367493514563856</p> <p>A pragmatic multi-method evaluation of one generic multidisciplinary CAMHS team of 10-12 clinicians, reporting service outcomes and clinical outcomes before and after implementing CAPA. Results showed improved service outcomes and an increase in patient flow (40% more cases seen, 15% reduction in waiting times). Clinical outcomes showed no reduction in</p>

	effectiveness, and a significant improvement in meeting the agreed goals of the intervention. Clinician-rated clinical outcomes were used, which may have biased results, and the case study method used limits the generalizability of the results.
2015 Mixed methods study Australia	<p>Naughton, J., Basu, S., O’Dowd, F., Carroll, M., & Mayberry, D. (2015). Improving quality of a rural CAMHS service using the Choice and Partnership approach. <i>Australasian Psychiatry</i>, 23(5), 561–565. https://doi.org/10.1177/1039856215597537</p> <p>Mixed-methods study examining the impacts of implementing CAPA in a rural CAMHS. Qualitative review of minutes from team and implementation group meetings showed that inclusive language has replaced the traditional, pathology-driven psychological discourse, though this has been met with mixed responses from stakeholders. Quantitative data from an internal audit showed that a wait list for clinician allocation has been eliminated, and average wait time between referral and first contact has decreased from 64 days to 11 days. Some adjustments to the guidelines of CAPA implementation were necessary in order to adapt the model to a rural Australian setting; the core role of an experienced, senior clinician was critical to the success of implementation. Study is the first stage in a longer research project on CAPA implementation and clinical outcomes.</p>
2017 Quantitative analysis Australia	<p>Naughton, J., Carroll, M., Basu, S., & Maybery, D. (2017). Clinical change after the implementation of the Choice and Partnership Approach within an Australian Child and Adolescent Mental Health Service, (2015). https://doi.org/10.1111/camh.12208</p> <p>Quantitative study investigating whether the implementation of CAPA was related to changes in client clinical outcomes and response times within a regional Australian CAMHS. Results showed that the implementation of CAPA improved the flow of young people through the service, with clients being seen in a more timely manner. Greater client throughput did not negatively impact clinical outcomes. Authors caution that interpretation of results should be made with caution due to a number of factors related to the fact that the study was carried out in a real-world service setting rather than a tightly controlled experimental setting.</p>

HEADSPACE

*articles in this section are listed in chronological order

<p>2015</p> <p>Mixed-methods evaluation</p> <p>Australia</p>	<p>Hilferty, F., Cassels, R., Muir, K., Duncan, A., Christensen, D., Mitrou, F., ... Katz, I. (2015). <i>Is headspace making a difference to young people's lives? Final Report of the the independent evaluation of the headspace program</i>. Sydney.</p> <p>Qualitative and quantitative evaluation of headspace: examines access and engagement; assesses outcomes of young people who have received headspace services; assesses the program's service delivery model; and conducts a cost effectiveness analysis of the program as it currently operates. Evaluation shows that headspace is accessible overall, and that it has been successful in attracting young people from marginalized and at-risk groups, as well as young people traditionally disadvantaged in their access to mental health care, including Indigenous young people and young people living outside of major cities. One group that headspace has not been successful in engaging is culturally and linguistically diverse (CALD) young people. Though stakeholders generally identified headspace to be accessible and engaging, some barriers described were standard opening hours, waiting lists, and concerns around cultural appropriateness of services in some centres. Overall, psychological distress decreased for 47% of headspace clients, did not change for 29%, and increased for 24%. In evaluating the service delivery model, family-based treatment and the provision of outreach services were identified as the biggest service gaps. The effectiveness of e-headspace was not evaluated. There was a large variation in average costs per occasion of service at the centre level, leading to a recommendation that centre level operational inefficiencies be identified, assessed, and resolved. Economic and social benefits from improved mental health attributed to headspace treatment included a significant reduction in the number of days lost or cut down due to illness, a reduction in suicidal ideation and self-harm, and a positive impact in reducing stigma and encouraging help seeking among young people.</p>
<p>2015</p> <p>Commentary</p> <p>Australia</p>	<p>Jorm, A. F. (2015). How effective are "headspace" youth mental health services? <i>Australian & New Zealand Journal of Psychiatry</i>, 49(10), 861–862. https://doi.org/10.1177/0004867415608003</p> <p>Opinion article responding to two papers publishing outcome data on headspace clients in conjunction with the Hilferty et al. (2015) evaluation. The author argues that while the data showed that more clients improved than worsened, in the absence of a control group, changes cannot be attributed to headspace care, and as improvements seen in headspace clients are similar to those seen in untreated cases, they may simply be due to spontaneous remission. Author asserts that unless it can be clearly demonstrated that headspace treatment is effective, it would be unwise to invest further in the headspace model.</p>

<p>2016 Commentary Australia</p>	<p>McGorry, P. D., Hamilton, M., Goldstone, S., & Rickwood, D. J. (2016). Response to Jorm: Headspace – A national and international innovation with lessons for redesign of mental health care in Australia. <i>Australian & New Zealand Journal of Psychiatry</i>, 50(1), 9–10. https://doi.org/10.1177/0004867415624553</p> <p>Opinion article responding to Jorm (2015). Authors argue that prior to headspace, Australian young people with mental health problems had the worst access of all to care, and that spontaneous remission was not working for them; their symptoms were not improving at all. The first external evaluation of headspace showed it to be accessible and acceptable, and to have improved access to care for traditionally underserved populations. Authors argue that access levels prior to headspace and where headspace does not yet exist are so poor that it has been very difficult to assemble a control group to compare youth receiving headspace services to, thereby making it difficult to accurately measure headspace’s effectiveness. They cite data to counter Jorm’s suggestion that the effectiveness of headspace could be assessed by comparison to samples of patients with mild to moderate depression where spontaneous remission can be observed. Discusses areas where headspace can be improved, and what further research is required.</p>
<p>2016 Commentary Australia</p>	<p>Allison, S., Bastiampillai, T., & Goldney, R. (2016). Australia’s national youth mental health initiative: Is headspace underachieving? <i>Australian & New Zealand Journal of Psychiatry</i>, 50(2), 111–112. https://doi.org/10.1177/0004867415621394</p> <p>Opinion article responding to the 2015 National Mental Health Commission (NHMC) report* that indicated that the headspace model was inefficient, with major problems in structure and governance. Based on the report’s conclusion that headspace had “under emphasized and under achieved” integration and coordination of services for young people in conjunction with state-based mental health services, tending instead to operate as silos, the authors argue that headspace centres should be aligned with states and territories, which is the level of government responsible for clinical services in Australia. *This report used data from a 2009 evaluation of headspace.</p>
<p>2016 Commentary Australia</p>	<p>Jorm, A. F. (2016). Headspace: The gap between the evidence and the arguments. <i>Australian & New Zealand Journal of Psychiatry</i>, 50(3), 195–196. https://doi.org/10.1177/0004867416632063</p> <p>Opinion article scrutinizing the arguments in McGorry et al. (2016). Author</p>

	<p>cites data from various sources to argue that: Australian youth have adequate access to mental health care apart from headspace; headspace is not adequately engaging young people beyond one or two sessions; the lack of a control group is a major limitation in evaluating headspace; evidence supporting the effectiveness of headspace treatment is weak, and for some claims, such as that it has substantially improved rates of days out of role and self harm, no data have been published. Author calls for more investment in exploring prevention, promotion of evidence-based self-help, improving social support, and aiming to reduce the “quality gap” (improve quality of services for more severe mental health needs) rather than the “treatment gap” (increase numbers of young people with milder disorders in treatment).</p>
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GAPS AND CONSIDERATIONS

<p>2014 Lit review</p>	<p>Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. <i>International Review of Psychiatry</i>, 26(4), 392–407. https://doi.org/10.3109/09540261.2014.928270</p> <p>Analysis of WHO data and peer-reviewed literature, using a multilevel framework, shows that the poor and disadvantaged suffer disproportionately from common mental disorders and their consequences; middle classes are also affected, and gender plays a major role. Adverse conditions in early life are associated with higher risk of mental disorders; family and parenting support, maternal care, childcare, and education have the potential to reduce inequities in the early years. Depression in adolescence is linked with adverse childhood experiences; school-based and family-building programs are cited as promising ways to reach children and adolescents.</p>
<p>2015 Commentary Canada</p>	<p>McLennan, J. D. (2015). Wait time to what? Could reducing wait times for child mental health services worsen outcomes? <i>Journal of the Canadian Academy of Child and Adolescent Psychiatry</i>, 24(1), 55–58.</p> <p>Commentary article: reports of clinical outcomes from child mental health service wait time reduction initiatives seem nonexistent despite potential benefits and harms. Targets for wait times for mental illness tend to refer to wait times until contact with the service system, with no specification for accessing specific evidence-based interventions. What patients receive after they make contact with various points in the service system for mental illness varies widely and specifics for the most part are unknown, especially in child mental health. Failure to specify access “to what” in wait</p>

	<p>time initiatives could lead to more harm than good. This could happen if: a) wait time is shortened to an intervention that has more harmful than beneficial effects (example: empirical literature has identified risks associated with grouping some high-risk youth together for interventions, leading to the opportunity for “deviancy training”) or b) wait time is shortened to an intervention that is ineffective, thereby diverting resources from the routine delivery of evidence-based interventions. Author expresses concern about shifting resources from delivering evidence-based interventions to something less than that in order to meet wait time targets. Reported practices of shifting to more “generic services tracks” and replacing more expensive care providers with less expensive providers, as noted in the Vallerand & McLennan (2013) study may require additional scrutiny. We need to be able to answer the question “wait time to what?” Leaving it as wait time to any possible contact scenario should not be acceptable. We need to measure clinical outcomes, as that is the only way we will be able to tell if shortening wait times is doing any good.</p>
<p>2015 Commentary UK</p>	<p>Williams, C. H. J. (2015). Improving Access to Psychological Therapies (IAPT) and treatment outcomes: Epistemological Assumptions and Controversies. <i>Journal of Psychiatric and Mental Health Nursing</i>, 22(5), 344–351. https://doi.org/10.1111/jpm.12181</p> <p>Narrative exploring the theory of knowledge that underpins the evidence-based perspective of CBT and how this influences service delivery, especially in the context of the UK Improving Access to Psychological Therapies (IAPT) program. The author argues that the IAPT culture is influenced by one research paradigm (positivism), which may skew services toward numerical outcome data as the only truth of recovery, and that inclusion of qualitative data in the form of service user narrative can assist in the evaluation of CBT and help researchers understand the context in which people live and how they access services. A qualitative research strategy to capture the lived experience of under-represented groups, such as sexual, gender, and ethnic minorities, is discussed.</p>